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A MEDICAL AND SOCIAL CRITIQUE OF DELINQUENCY*

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IT is appropriate that I should begin my brief contribution to this colloquium by praising your association for having arranged it. I do this out of a spontaneous enthusiasm fully sensed, but also, I suspect, as a credit that I hope to check up in advance against the debits of some general criticisms that I may level against your profession later on.

It is to your collective and abiding credit that you avow it as your conviction that "basic revisions are required in the body of the law and in legal administrative proceedings" to bring about effective prevention of juvenile delinquency, and it is likewise creditable that you have invited us, representatives of other professions, to confer with you on the nature of those required revisions.

I must, however, state forthwith that, in my studied opinion, though "revisions in the body of the law and in legal administrative procedures" may contribute a modicum toward prevention, the genetics of juvenile delinquency, whatever they may be, are really little affected by the law or its administration. The "rebel against authority," to use the phrase in your Statement of Purpose, is not a rebel primarily because the law is bad, or because it is badly administered. Indeed I am convinced that the entire process of "law and punishment" has valency only for the law-abiding, and not for the criminal. The deterring effects of punish-

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ment are best to be witnessed in the normal and not in the criminal population.

All of this, however, is not intended to deny to the legal profession an effective rôle in the effort to meet and to master the challenge of juvenile delinquency. On the contrary, I believe that the legal profession has great capacities in these connections, but it is my belief that these capacities will have to be exercised in fields beyond and in addition to the "body and the administration of the law."

Let me at this point confess that I am cognizant of the rather belligerent tone of my opening statements, and I hasten to add that this tone is intended. I deem it not only warranted, but necessary, for to reach to the "roots of juvenile delinquency," we must first radically change the reference framework within which we conceive the problem. And the prevailing framework will not yield, except to an aggressive assault.

Let me illustrate this by dwelling upon and by analyzing the implications of the expression, "the rebel against authority," which I quoted from your Statement of Purpose. This phrase appears innocent enough, yet, upon inspection, it is seen to embrace a corrupting fiction. The picture suggested is something of this order: On the one side stands authority, and on the opposite side a youth who, for some reason or other, *will not accept* or yield to authority, but rebels against it.

Suppose I suggested—as indeed is most often the case—that the figurative youth confronting authority does not see it as authority, but rather as his particular and fearsome enemy. Would he then still be a rebel? Or, again, suppose that the figurative youth *did* recognize authority, and even had a wish to yield, but could not, would he then likewise be a rebel? I know, of course, that further on in the Statement of Purpose, from which I lifted the phrase, "the rebel against authority," there appears this seemingly redeeming affirmation, "The essential concept is that the juvenile delinquent is sick rather than 'guilty.'" But to this I must add the query, "Sick, how—as of typhoid, or as with rickets?" for this makes all the difference possible!

The most liberal view of the criminal is that he is sick, and that in the main he should be treated, not punished.

In so far as this view has displaced that of "social vengeance," it is indeed a liberal and progressive view. But then we must examine critically this idea of the sickness of the criminal, or else we are likely to bog down in a quagmire of sentimental and ideological futility.

The idea that the criminal is a sick person is really not very modern nor of very recent origin. Lombroso, for example, in the latter half of the last century, advanced the idea that the criminal was such because he was a sick man: his constitution, as was to be witnessed by certain anatomical stigmata and physiological variations, was such as to *disenable* him from being law-abiding. Lombroso's data, and his basic conception of the constitutionally criminal man, have since been discredited. But the idea of the criminal as a sick man was not thereby affected; only the sphere of the illness was shifted from the anatomical to the sociological.

In support of this, vast numbers of books and a great many articles have been written, and untold statistical calculations have been made, to prove that the criminal, to phrase it baldly, is a victim of poverty and all its attendant evils. The social theory of "criminality" carried more conviction in the first decades of this century than it has since, for it has not met certain critical challenges, such as the question why all those who live in poverty do not turn criminal, or, conversely, why the middle-economic and the upper-economic groups are not immune to criminal impulsions and activities.

In more recent years, the sphere of illness wherein the criminal is thought to be affected has again been shifted, this time from the sociological to the psychological. The prevailing theory is that the delinquent person, like the neurotic, is the victim of a psychopathic condition. According to Franz Alexander and William Healy, the "chief difference between neurosis and criminal behavior is that in neurosis the emotional conflict results in symbolic gratifications of unsatisfied urges, whereas in criminal behavior it leads to overt misdeeds."[1]

In the light of this brief review, it is to be seen that the essential concept of the juvenile delinquent—and of his elder

[1] See *Roots of Crime*, by Franz Alexander and William Healy. New York: A. A. Knopf, 1935.

brother, the confirmed criminal—as personages more sick than guilty, is in fact a rather familiar and well-rounded concept. It is well rounded precisely because, though in time the emphasis as to the sphere of illness has been shifted, the concept retained and now includes the constitutional and the sociological as well as the psychological components. It is familiar because all the leading criminologists since the time of Lombroso have harped upon it.

Yet I must present that despite all that recommends it to our minds and to our hearts, this concept of the delinquent as a sick person, even as it is now commonly formulated, is in some parts erroneous and corrupting. It impedes rather than advances our understanding of delinquency. It largely misdirects and renders our labors ineffective. So grave a challenge, I am aware, calls for a prompt defense.

That which is erroneous and corrupting in the current concept of the delinquent as a sick person is the implied and often expressed correlated question: "What makes this sick person—*i.e.*, the delinquent—sick?" Specifically, the trouble lies with the animistic word, "*makes.*" For the image it inspires is that of an otherwise normal person who, by the accident of having been exposed to and affected by some malevolent force, has been made abnormal—that is, sick. This, of course, is the familiar etiological formula so very common in medical thinking. A so-called normal man accidentally swallows some typhoid bacilli—and develops typhoid. The man, in other words, was *made sick* by the typhoid bacillus.

This scheme is both simple and clear. The only trouble with it is that it is incorrect. What makes a man sick—if I may use this phrasing for the present, even though I intend later on to discredit its validity—is the conspiracy, the interplay of many forces, both present and absent, among which the bacillus is only one, and not necessarily the most important one.

In the instance of criminality in general and of juvenile delinquency in particular, the etiological scheme implied in the question, "*What makes the criminal?*" proves particularly corrupting, for it sets us, the so-called normal, healthy, law-abiding citizens, completely apart from the object of our inquiry. It exculpates us from all blame and exempts

us from having any share in the criminality of the criminal. We thus achieve a situation that salves our ego, and even permits us to indulge in that most pharisaical and blasphemous contemplation, "There, but for the grace of God, go I!" As if it were all up to God, or to fate, or to what you will—but not including us!

The inquiry on juvenile delinquency, and on criminality in general, must not be framed in terms of what *makes the criminal,* but rather in the obverse: What enabled the larger percentage among us to develop into socially functioning individuals? What enables us to run the gantlet of our primitive drives and impulsions, while the others fall behind?

If the delinquent is to be considered "a person sick," then his sickness is of the nature of rickets—a disease of deprivation, and not of exogenous origin.

There is current in the literature of criminology a term original with the vernacular of the ecclesiasts. The term is *recidivist.* It means "a backslider," "one who relapses." This term does not fit the delinquent, for how can one who has "never arrived" backslide or relapse? I recall in these connections the compassionate words of Cardozo. In his address before The New York Academy of Medicine, entitled, "What Medicine Can Do for Law," and delivered just twenty years ago, he said:

> "Run your eyes over the life history of a man sentenced to the chair. There, spread before you in all its inevitable sequence, is a story of the Rake's Progress more implacable than any that was ever painted by a Hogarth. The Correctional School, the Reformatory, Sing Sing, or Dannemora, and then at last the chair. The heavy hand of doom was on his head from the beginning. The sin, in truth, is ours—the sin of a penal system that leaves the victim to his fate when the course that he is going is written down so plainly."

The truth is that from "the beginning" the heavy hand of doom is upon every man's head. From some it is in time lifted; from others, never. This most certainly is the foundation principle of modern psychiatry—that man is born a grossly asocial animal. The child, in the words of Freud, comes into this world a polymorphous-perverse creature, ridden hard and fast by its primitive, instinctual drives. True, that isn't all! The human infant brings into life the potentialities for loving and a large capacity for learning by experience. But whereas its primitive, instinctual drives

are given, the capacity to love, the altruism that renders possible human companionship and social coexistence, must be realized in experience. In far too many human beings *that* experience is wanting. Such experience as they *do* suffer inhibits rather than advances their socialization. Their primitive antisocial impulsions are intensified rather than sublimated. They develop an Ishmaelite personality, charged with the accursed conviction that every man's hand is against them, and theirs against every man.

I have cited a passage from Alexander and Healy to differentiate between neurotic behavior and criminal behavior. But the difference cited serves also to reveal their common derivation. Neither neurotic behavior nor criminal behavior is individually or socially effective, and at the root of both failures lie the unrealized potentialities for loving.

I am aware that the above formulation is a very broad one. Yet it is correct and sound. It remains valid despite the exceptions that can be cited. There is no doubt but that there exist some so-called constitutional psychopaths whom nothing on earth—or at least nothing that we know of—could render normal and socially adapted. There is no doubt but that experiential and environmental factors may be of so violent and so disruptive a nature as to break down a heretofore well-integrated and socially adapted person. Our war experience has demonstrated that.

But while all this is true, it is likewise true—and vastly more pertinent, because it *is* the rule and not the exception—that delinquency represents a failure in personality development; it is, in other words, a widespread deficiency disease.

The most characteristic feature of the deficiency diseases is that they can be cured and can be prevented *only* by supplying the involved organism with the factors in which it is deficient. One can cure malaria with quinine, pneumonia with the sulphonamides, syphilis with penicillin. But rickets can be cured only by supplying the lacking vitamin D—plus calcium, scurvy by the lacking vitamin C, and beri-beri by the lacking vitamin B. Iron anemia is cured with iron, and diabetes is treated with insulin, for these also are deficiency diseases.

From this we can promptly and easily understand why our "penal therapy" has been so ineffective, why our pro-

bationary, reformatory efforts are so largely futile. The Gluecks reported that of 510 individuals who left the Massachusetts Reformatory (1911–1922), 80 per cent continued in criminal activities for as long as five to fifteen years after their release. In 1933, of 17,017 juvenile delinquents committed to institutions by the courts, approximately 50 per cent had already acquired an institutional or probational history. The trouble is that our "penal therapy" in the first instance is applied too late, and in the second is of the wrong kind.

It is pertinent now to inquire what—if at the root of the neurotic's and the criminal's failure to become individually and socially effective lie the unrealized potentialities for loving—what withered those potentialities? Here it is all too easy to pass the blame on to some one or more individuals of and within the neurotic's or delinquent's sphere—his mother, his siblings, his father, and so on. This process shifts, but does not resolve, the problem. For if we say that the parents failed the delinquent, then the question is, "Why were *they* delinquent?" The problem cannot be resolved by the technique of the scapegoat. It is too broad for that.

Alexander and Healy chart five determining factors in personality formation. One is constitutional—that is, hereditary and intrauterine. The next three are of an environmental order—that is, "early acquired reactive tendencies," "family influences," and "influences of the social environment in a broader sense." The fifth is "general ideological trends in a given civilization." On critical scrutiny it will be seen that the middle three of the five listed factors are in effect but particular instances of the fifth listed factor. The general ideological trends in a given civilization have a determining influence on early reactive tendencies, on the family, and of course on the social environment. We can thus reduce the five factors determining personality formation, to two: the hereditary-constitutional and the general ideological trends in the given civilization. It is in these, then, that we should seek and are likely to find the answer to the question, "What impedes the realization of the individual's potentialities for loving? What retards and arrests the development of the involved personality toward individual and social effectiveness?"

Viewing the two given factors in the perspective of history, one sees that one has bettered in time, and the other has grown worse. The hereditary-constitutional factor, certainly within the last hundred years, has become increasingly more favorable. Modern science has vastly improved the constitutional equipment that the average child brings with it into this world. But during this same period and longer still the "general ideological trends" of our given civilization have consistently grown worse.

It would require the gifts of a Jeremiah, his wisdom and his zeal, to do full justice to the last segment of my thesis. Yet any one, even though he be not Hilkiah's son, can grasp the central fact that the ideological trends of our culture are primarily egocentric, competitive, and aggressive. Ever since the Renaissance, when the individual was "rediscovered," our social dynamics have leaned toward the centrifugal rather than toward the centripetal. There has gone on a steady process of dismemberment, affecting every phase and every segment of human life and experience. Work, the crafts, the community, the homestead, the family, everything, as Toynbee has so well shown in his monumental work, has become "parochial." And we witness the effects in our global, hemispheric, national, regional, and domestic life. We witness it not least in the high incidence of neurosis, and in the widespread incidence of delinquency.

Neither time nor my competence will permit me to particularize further. Besides, I feel it is my obligation only to define the thesis—not to defend it. Yet should you want to follow this argument further, you will find it elaborated by many. You will find it in Toynbee's works; in the books of my friend Karl Menninger—in his *Man Against Himself* and in his *Love Against Hate.* The book entitled, *Modern Woman, the Lost Sex,* by Lundberg and Farnham, deals with an important phase of this problem—the historical disintegration of the relationship between men and women. Franz Alexander has dealt with this theme, and to add one final title, Halliday's recent book, *Psychosocial Medicine,* contributes substantially to the illumination of this subject.

Of course the crux of the matter is: What's to be done? But before I turn to that, I must set up a barrier against the misinterpretation of my lugubrious résumé of human

progress since the Renaissance. I mentioned Jeremiah. Though I deeply admire him, I do not intend to ape him. I would not have us "turn back the tide of time," discredit the progress we *have* made simply because it has not been coextensive in all directions—has indeed been purchased at a loss in certain segments of being. I would not return to the ways of our fathers, good as their ways may have been for and in *their* days. In other words, I see our redemption in going forward and not in turning back.

So much in order not to be misunderstood. Now to the question, What's to be done? Palpably, the cultural atmosphere of our civilization must be altered so that it favors the realization of the individual's potentialities for loving. This I recognize is a large order, and one given with few details. Yet I will offer one detail—the most important one, I believe, and the one that most directly pertains to the objectives of this colloquium.

The cultural atmosphere of a given civilization is deeply affected by that civilization's spiritual and intellectual leaders. What we need to-day, above everything else, is such leadership. When you invited us to take part in this colloquium you asked us, among other things, to counsel *you,* the legal profession, how and what you might contribute to the resolution of the problem of delinquency. My counsel is offered you bluntly—take on the leadership that is your prerogative. Trouble less about the law and its administration and more about the social organism to which the law applies.

I dare not be rash in my criticism, fearing that I might come in judgment before you, yet I have heard it said that the lawyer is too much the hired servant of the litigant and too little taken up with the ultimates of law and society. I would counsel you to step out beyond your fields, even as—God forgive me for my sins!—I have this once strayed beyond mine. Singly and collectively develop and contribute your leadership to sweeten and render propitious for the better parts of man the world we live in. Certain it is that we want broad knowledge and penetrating vision to understand and to help heal the ills that beset us. And we want as much to protect us against the fanatical quacks who are busy

peddling their social nostrums. Here, too, your profession, with its dialectic skills, can prove of particular use.

I must now end. I have attempted to reach to the roots of the problem of delinquency—and I am afraid that some of you, more witty than charitable, might say that I have been up in the air all the time. I will come *down to earth* long enough to offer three recommendations, which your association might consider. Bluntly, they are these: to create colonies for the confirmed criminals, so as to enable them to lead productive and as nearly normal, yet segregated, lives as is possible; gradually to do away with reformatories and to place juvenile delinquents in properly selected foster homes; and to train a large body of psychiatrically *informed* and alerted teachers, nursery-school supervisors, nurses, and social workers, to keep guard over our young and to take note of the earliest variants from the normal. These *avant-gardes* should be supported by widely distributed child-guidance centers.

Finally I must offer my apologies—and I do so in the words of Cardozo, but little altered: Nothing I have said was spoken but as a gesture of friendliness—"the friendliness that is due between groups united in a common quest, the quest for the rule of order, the rule of health and of disease, to which for individuals as for society we give the name of law."

THE CHILD-GUIDANCE CLINIC AND COMMUNITY MENTAL-HEALTH PROGRAMS *

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IT will be the purpose of this paper to present a view of the child-guidance clinic as a community agency that defines its activity not only in terms of its traditional functions of psychiatric diagnosis and treatment, but equally from the standpoint of its consultative and participant relationship to other health, welfare, and educational agencies in the community. In general, one may say that the practice of the child-guidance clinic derives meaning and validity from the manner in which it is able to define and to carry out these community responsibilities.

From the point of view of the community, the clinic may be regarded as an extension, with greater specialization, of mental-health processes that are inherent in the organization and function of the community itself. In other words, the mental health of children is a community responsibility in which the clinic shares, not only through its special interest in the failures in social adaptation, but perhaps in a more important sense through its awareness of the fundamental psychological needs of all children, and how they may be met.

In these days, when many new community clinics for children are being established with the help of the National Mental Health Act, it is especially important to emphasize repeatedly the public-health aspects of clinic function and their possibilities for the development of a preventive psychiatry. We have no preventive psychiatry to-day. We do have a large reservoir of psychiatric knowledge, enormously widespread public interest in the field of psychiatry, and even some belief in the utilization of psychiatry to save the world from atomic self-destruction; but we do not have in psychiatry even the simplest type of generally recognized and

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accepted epidemiological method that might be put to work to reduce human anxiety and distress.

The children's psychiatric clinic has the nuclear function of providing psychiatric care for the emotionally and mentally disturbed child, but it also has the important related function of adding its strength to community effort on behalf of all children. Under certain conditions, the clinic may become unduly preoccupied with its nuclear function. In the first place, it may be set up in a community in which there is little actual or genuine interest in the welfare of children, as indicated, for example, by the absence of suitable standards in the employment of social workers; low salary scales for social workers, nurses, and teachers; inadequate school budgets; the absence of supporting special services in the schools, particularly properly supervised school social work, nursing, and psychology; the neglect of foster-home placement for dependent children and particularly infants; the absence of a properly staffed juvenile court; the lack of a well-administered child-welfare program; and the neglect of programs of maternal and child health. These may be considered the indices of a community's failure to maintain interest in its children. In such a community, the establishment of a child-guidance clinic is a direct appeal to magic; it can only represent a gesture of riddance of responsibility, a method of easy appeasement of social guilt.

The clinic may also falter in its social obligations through a failure of its own leadership. In this connection, there is a serious shortage in the number of available child psychiatrists with even minimal training in the clinical job, and there are even more serious deficiencies in our basic concepts of training in community psychiatry. After all, as psychiatrists, we are still not too far removed from the locked wards of the asylum. We have had little time and less experience to make it possible for us to meet the challenge of charting new ways of community service, to develop new methods adapted to an epidemiological view of emotional disturbance, to train a new generation of psychiatrists who are free from institutional prejudice and who can practice as participants rather than as detached observers in our social processes.

This idea of social or group participation is relatively new

in psychiatry. It implies a concept of illness as a distributive process in which the interpersonal relationship pattern of the disturbed individual must be given as much consideration as internal events in the patient. On a small scale, the type of practice in the child-guidance clinic supplies an interesting illustration of how this idea can be put to work. The child's problems are regarded as an expression of disturbances in his primary relationships in the family as well as in secondary relationships in school; and in the treatment process, the participation of the mother is regarded as almost indispensable in most cases, and work with the school is often found to be of great value.

Psychiatric work with the mother is oriented to helping her explore disturbed feelings she may have about her child and the problems he presents. A sense of failure as a parent is almost universally present, along with various specific expectations and misconceptions about the rôle of the clinic and about the nature of her responsibility in the treatment process.

The clinic's work with the school, on the other hand, has not always been distinguished by any understanding of the problems or the feelings of teachers. A common error arises when the clinic, having studied the child and the family, sends the school a letter embodying a series of recommendations, which are often extremely irritating to teachers. For example, the recommendation that Johnny needs love and affection obviously implies that he has not been getting it from teacher. Recommendations that Johnny be given special consideration, individualized tutoring, an opportunity for a wholesome relationship with a male teacher to make up for the lack of a father, promotion, change of class, change of school, and so on, often accomplish little more than to confirm the school's suspicion that the clinic has all its feet firmly planted in the clouds, and has no real interest in helping the school. Such recommendations imply that the school has not tried everything at its disposal to help Johnny, and create the impression that the clinic is blaming the school for not being able to handle a problem which the school in turn had innocently thought the clinic would take over, treat by some mysterious formula, and return as cured.

What all this adds up to is that the clinic very often does

not have the remotest idea of what goes on in the school, and *vice versa*. It makes the point that a psychiatric service extended to any organization must be oriented to the problems of that organization, and must find some way of participating actively and continuously, even if tangentially, in the administrative and functional aspects of the organization, or else the psychiatric services themselves may seem to become inconsequential and irrelevant.

In relation to the public schools, we have attempted in our clinic to follow through on a number of procedures with the object of bringing about a greater degree of mutual understanding and acceptance between our workers and teachers. Whenever a case is referred by a school, we expect that the social worker assigned to the case will visit the school and find an opportunity to talk with the child's teacher, and we invite school personnel to attend conferences in which the case is discussed.

In visiting the school, the worker does not come with criticism or authoritative advice, but with the idea of discussion and mutual exchange of information. We have found that teachers, like parents—and both often quite unnecessarily—carry a feeling of personal responsibility and failure, and are, therefore, particularly sensitive to anything remotely resembling criticism. The worker's visit may provide the teacher with an opportunity to examine her feelings about the child, her anxieties about his behavior, and her personal guilt and tension in relation to the problem. The worker's visit may then bring the teacher a clearer perspective about the nature of the problem and reassurance as to her rôle in it.

The clinic has also been active in setting up a school-agency coöperation program under the auspices of the Council of Social Agencies. Its object has been to obtain recognition for the view that the school is one of the most important social agencies concerned with the welfare of children, and that if a method of coöperation between the schools and other social agencies with similar interests could be worked out, it would be of great advantage to both—and to the children. We have also taken part in discussions with personnel in the schools around the problem of implementing their mental-health resources, and making more effective use of the facilities of the child-guidance clinic. Finally, we

have participated in innumerable Parent-Teacher Association programs, and have provided psychiatric time for the pre-school parent-education program.

The community clinic's relation to the schools, then, may be many-faceted and complex. From the standpoint of preventive psychiatry, it may be described as participant activity in receptive group functioning, where receptivity is determined by the interest of group leaders in the conservation of human values in interpersonal relationships. In this sense, it is a teacher-oriented program, directed toward easing teacher tensions, and helping teachers toward greater acceptance, readier understanding, and more relaxed handling of the emotional problems of children. To the extent to which this can be accomplished, it offers values to all children as well as to all teachers in the schools. This is not alone a psychiatric problem, since such a goal is also dependent upon such factors as size of classes, effectiveness of teacher preparation, salary scales of teachers, and attitudes of administrative personnel.

But psychiatric service may assist the schools in discovering and making conscious the resources which are already available within the educational process itself in maintaining the mental health of children. There is little doubt that the schools are now doing a great deal to help many individual children resolve their emotional problems and settle into social adaptation. However, it is usually the contribution of the intuitive teacher meeting problems through special talents rather than through special training.

Teachers want and should have more training in the dynamic aspects of personality development of children. They should have more opportunity to develop their interest in and understanding of the meaning of behavior and particularly of deviant behavior. There should be better teacher selection from the standpoint of emotional maturity and balance. There should be constant study and restudy of the curriculum in the interest of meeting the individual needs of children, and particularly the needs of the exceptional and the handicapped child. There should be constant study of the difficult problem of the integration of supporting psychiatric services, especially psychology and social work, into the administrative and functional structure of the school.

And finally, there is the particular and urgent need to develop better understanding between the schools and the community.

I have stressed the relationship between the clinic and the schools because of the influence teachers may have on the social and emotional development of children. While it is true that the main formative influences have their roots in family experience during the first five or six years of life, modifying processes go on continuously during the school years, and have important results on such personality traits as spontaneity, response to group experience, intellectual and emotional resourcefulness, stimulation and control of imaginative impulses and creativeness, and richness of cultural integration. Furthermore, the schools may and often do provide substitute experiences of all kinds for children whose family life is constrictive and depriving. They offer children substitute parental identifications by means of which extensive ego modification and ego strengthening may take place.

I shall now discuss one other important aspect of the clinic's activity—*i.e.*, its interpretative and coöperative work with social and health agencies. These are agencies that render a variety of social and health services to children and their parents. As examples, I might cite the aid-to-dependent-children programs, foster-home and institutional placement of children, supervision of delinquent children, maternal and child-health programs, especially the child-health conference, prenatal clinics, the crippled children's programs, and the premature-baby programs. All of these are services to children and parents with emotional problems secondary to family, economic, personal, and health-care difficulties. In every instance, the worker is dealing with persons in whom adverse or critical life experiences have created anxiety, feelings of insecurity and uncertainty, and a need for special understanding and emotional support.

Even where the services are set up to deal with normal problems, as in the prenatal and well-baby clinics, a host of common anxieties are routinely encountered. The pregnant mother, for example, and particularly the primipara, may have anxieties about the birth experience, fears of dying in child birth, fears of body mutilation, feelings of inadequacy in relation to being a mother, impulses of rejection of the child and of hostility to the husband, and increased feelings

of dependency. The mother who is attending a well-baby clinic with her first child may, and very often does, have anxieties about every aspect of baby care, with much confusion between the needs of the baby and her own needs, and cultural pressure and superstition. She reflects her anxiety with a multitude of questions, which are as much a bid for reassurance as for information. In most well-baby clinics, lack of time and of trained personnel result in the giving of information which often cannot be assimilated because of the failure to recognize and deal with the underlying anxiety.

There is certainly no doubt that social and welfare agencies include among their clients a very large number of persons with major psychiatric problems who have no interest in and are to all intents and purposes completely inaccessible to direct psychiatric treatment. Their concern with immediate problems of survival and with heavy burdens of family care under conditions of economic deprivation leaves them neither the interest nor the energy to isolate and deal with the effect of their feelings on the course of their lives. They are only able to deal with recurrent situational emergencies, for which they need the help of the agency, and under these circumstances they may come to develop an emotional dependence on the case-worker, with resulting psychotherapeutic benefit.

In her work with the problems of these disturbed people, the case-worker, trained or untrained, can get a great deal of security from the backing of the psychiatrist by sharing his understanding of their personality structure and defenses. An understanding of the behavior of the difficult client makes it easier for the worker to give him acceptance and perspective, and to help him in working out his own problems.

Here, then, is a type of psychiatric consultative service which the clinic can offer to social and welfare agencies. The main object of the service is to help the worker in the more effective management of her own professional responsibilities. The emphasis is not on screening patients for reference to the clinic, although this is important in the interest of good clinic function, nor on any kind of direct service to patients. It is a worker-centered orientation, meeting the worker at her own level of awareness and skill, and helping

her to make the best use of her own professional resources in her work with clients. The psychiatrist assumes no responsibility for the care of the client, except of course in the relatively rare instances where psychiatric treatment is clearly indicated. Nor does he assume responsibility for the activity of the worker—*i.e.*, he does not assume a supervisory function. He limits his rôle to sharing with the worker the degree of awareness and understanding of personality of which she is capable. Such a consultative program does serve the basic function, in our experience, of providing the worker with very real reassurance and support, which is in turn reflected in more relaxed work with clients.

The relation of the child-guidance clinic to health agencies, and particularly to the work of local public-health units, is directly influenced by the lack of psychiatric orientation and training of public-health nurses. The undergraduate training that nurses receive in psychiatric hospitals seems to have no carry-over value to community psychiatric problems. We find that the public-health nurse, unlike the social worker, has had no academic or practical preparation in dynamic psychiatry. She has had no opportunity to become acquainted with dynamic concepts in child development and personality adaptation, has had no training in the principles of interviewing, and has not developed a system of supervised practice which can compare in any way with the highly refined and consciously professional activity of the trained social worker.

Nevertheless, the public-health nurse is in a position of great strategic importance for the development of an effective community and preventive psychiatry. Her coverage of rural areas is now better than that of the social worker and will presumably become more so. She is directly involved in many crucial problems of health and illness, and is constantly being placed in the position of having to give advice to mothers on problems of child rearing and child behavior. The tradition of home visits remains and will remain a corner stone of practice with the public-health nurse, while the social worker moves in the direction of increasingly frequent office visits.

I am not suggesting that the social worker and the public-health nurse have similar or overlapping functions. It does

seem to me, however, that the social worker has attained much greater clarification of function in relation to her activity with the emotional problems of clients, and that the nurse with a newly aroused interest in mental-health problems often exceeds her own functional limitations, and moves into areas that properly belong to the social worker. Moreover, I believe that this is an inevitable tendency and that it will continue to create conflict of feeling between social worker and nurse until the latter has caught up with her training deficits in community psychiatry, and is then in a position better to clarify, define, and limit her function in the field of mental health.

One of the major difficulties in training the public-health nurse in mental health is the lack of development of public-health clinics with integrated psychiatric service. Because of this lack, many nurses who are now in training to become psychiatric consultants are attending schools of social work, where they can at least obtain dynamic concepts and supervised field experience in interviewing procedures and in the utilization of community resources for patients. However, there will still remain the very great difficulty of translating social-work training into nursing practice.

The solution seems to lie in the development of psychiatric training resources that are specifically keyed to the requirements of public-health nurses—for example, through the development of integrated psychiatric services in child-health conferences and prenatal clinics. Here, the child-guidance clinic is in a unique position to offer leadership. It has the experience of dealing intensively with maternal attitudes; it has an understanding of the range, the variety, and the meaning of the responses of mothers to their children; and it has wide experience in clinic team practice and community participation.

On the basis of our own experience, we have come to the conclusion that there is no place, at least at the present time, for the public-health nurse as a member of the team function of the child-guidance clinic. If the nurse is to get training in this field, it would have to be in relation to psychiatric services that are developed in the field of public-health clinics. We are, therefore, now proceeding to assist in the setting up of model well-baby and prenatal clinics, in which the

services of psychiatrist, psychiatric social worker, and clinical psychologist will be integrated with the basic functions of these clinics so that they may serve as field training units for the public-health nurse in mental health.

In summary, I have indicated some of the many possible channels that are available to the child-guidance clinic in working toward the goal of an effective public-health psychiatry. Emphasis has been given to the rôle of the clinic as a community agency, and the opportunities for sharing its knowledge of personality function and disturbance with community workers who have to deal with people's problems. There has been some discussion of methods of psychiatric consultation and service in relation to the public schools, welfare agencies, and public-health nursing.

Finally, I would stress the view that the child-guidance clinic is only one of the many resources in a community available for the protection of the mental health of children; that the effectiveness of its work is dependent on the extent and quality of supporting services for children as an index of the community's interest in their welfare; and that the absence of such interest may be an insuperable handicap to the development of an adequate child-guidance-clinic program.

COUNSELING IN EMOTIONAL PROBLEMS *

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JOHN comes to the counseling office with a note from an instructor, stating, "There is something wrong with this boy emotionally. He breaks out in a nervous sweat every time I call on him to recite. Please advise."

As I face you to-day to deliver my speech, I "break out in a nervous sweat." Is there "something wrong" with me emotionally as well as with John?

Bob staggers in noisily during the wee, small hours of the night—light of head, light of heart, light of purse. He has held his own with the best of them during the long hours of that bull session. You are annoyed at his lack of self-control and want help with his "emotional problem."

What makes his problem so much more serious than yours when you are light of purse, having invested more than you should in that spring hat which helps you feel that you can hold your own and gives you self-assurance? Bob and you are both meeting basic emotional needs for recognition and approval. What makes one light purse an emotional problem, the other not?

Emotions are common to all of us. At times "we stumble over them"; at times we are propelled forward by them. But at no time are we too old or too young, too intelligent or too "dumb," to have emotions and emotional difficulties, for every experience from earliest childhood on through life has some emotional concomitant.

If emotions are universal and normal and the range of the normal is exceedingly wide, what makes one emotional reaction a problem, another not? The difference between normal emotionality and an emotionality that may become pathological is a relative one of degree, duration, and discharge. It is a question of whether the reason for and the

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intensity of the emotion are in keeping with the cause. It is a matter of the manner in which the emotion is handled and whether the feeling is allowed to interfere with the smooth functioning of the individual over a longer period of time than is warranted by the causal factors. For example:

Mary is furious because her classmates will not elect a certain student to office simply on the basis of race. Mary translates her emotion into action. She presents the student's fine scholastic standing and leadership qualities to the committee. When there is no favorable response, she submits the problem to the whole class. When her proposal is again turned down, she accepts her defeat realistically, continues on friendly terms with her classmates, and seeks other avenues for removing racial discrimination from the campus.

Betty also is furious. She has received a "D" in history, which she took only because it was a "snap" course. She storms. She weeps. She blames everything but herself. She indulges in daydreams about "showing up" her instructor. She does nothing to improve her study habits, her attendance, or her attitudes. She belittles her instructor and history in general at every opportunity throughout the quarter.

The same emotion—anger—is an expression of a healthy maturing social consciousness in Mary, but it is a sign of immaturity and poor adjustment in Betty. In one girl the emotion is in keeping with the cause and is short lived because it is converted into healthy action. In the other girl it is allowed to generate further tension and conflict which, if not adequately resolved, can become a serious emotional problem.

Tensions and conflicts are not important if we think of a student mainly in terms of a mind to be filled with knowledge and disciplined. They are of prime importance if we believe that the whole student comes to school and that he is our responsibility, mentally, emotionally, and physically.

Let us consider Joe for a moment. He is "flunking" psychology. He claims that he spends hours over his assignments, but does not seem able to grasp what he reads. He is listless and complains of dull headaches. He is frequently absent from class because he is ashamed of his inability to recite.

Psychological tests show adequate ability and interest for work on a college level. Physical check discovers only a slight error in vision which is not significant in the problem.

It is only when we consider Joe as a total personality that we find an answer to his problem. A complete study reveals a boy preoccupied with threatening thoughts of heredity. He has always looked like his mother, who is in a mental hospital. He watches himself for similarity in behavior and he sees in his inability to concentrate proof of the beginning of a deviation from the normal. His anxiety and tension are so great that there is no energy left for the business of learning or for maintaining normal relationships on the campus. It is only as we understand the whole of Joe that we can help him.

His classroom readiness and efficiency depend on our understanding of his emotional needs, his total personality and environment.

The physical status of a student can be checked by examination and laboratory procedures. An indication of his mental capacities can be secured in part by tests and measurements. But his behavior, which is emotionally determined, presents a difficult problem because of the complexity of emotions and the lack of adequate measuring instruments and techniques. What we would have to measure to understand the student's behavior is the sum total of all his experiences—the ways in which he has met and is meeting his basic emotional needs for security, sense of belonging, adequacy and self-esteem, his need for recognition, for approval, and for adventure. And since emotions are processes and not things, we would have to measure, not only his manner of meeting emotional needs within himself at a given time, but his way of resolving them at all times under varying and variable environmental pressures.

The problem is further complicated by the fact that to-day the student lives in a world that calls for ability to make choices and arrive at decisions as an individual. But he has all too frequently not been given an opportunity to develop this ability.

In this setting, conflicts arise that prevent satisfaction to the individual and social acceptance. It is these conflicts that become emotional problems when they are not adequately resolved, but are allowed to manufacture anxieties and ten-

sions, interfering with his performance as a mature individual and a member of society.

Fortunately or unfortunately, there is no answer sheet or graph to refer to in evaluating individual behavior. There is no blanket understanding of emotional reactions. Our understanding of each person's reactions has to be individualized, for into every new life experience we bring the sum total of all previous experiences, which have different emotional values for every individual.

At no time can we generalize even in so seemingly simple a matter as low grades and say that they are the result of poor ability or application. John may be inadequate intellectually, but for one John there are nine others whose poor performance has to be understood on the basis of personality, life experiences, and emotional reactions peculiar to that individual student in that particular setting.

Such an individualization shows that Joe cannot do adequate work because his marriage is going on the rocks and he cannot keep his mind on his studies. Mary is doing poorly because mind and body are sluggish as a result of severe anemia. Bob is carrying a full academic load and working long hours to put himself through school and support a family, and there is neither time nor energy for his studies. June has given up trying because her parents are never satisfied and expect straight "A's."

Each student presents an individual problem and has to be understood individually.

In brief, then, emotions are universal and normal. They create problems only when their onset, intensity, and persistence, and our manner of handling them are out of keeping with the causative factors to the extent that they interfere with our adjustment. Emotional problems can be resolved when they are examined and understood in the light of the whole individual and his total environment. There is no all-inclusive answer. Each problem has to be studied separately, each student considered as a separate individual and helped to attain *his* continuing emotional balance.

To be able to do this, we, as counselors, must be alert to symptoms that might be indicative of a threat to that balance. Our task, however, is not mainly one of helping the individual who has lost emotional balance to regain it. It is much more

important that we prevent that loss of balance by recognizing the danger signals, the early symptoms of emotional problems. This is not easy because of various peculiarities of symptoms.

Sometimes the symptoms are far removed from the fundamental causes and have to be traced patiently and painstakingly through all the ramifications to their true sources.

The same symptoms may be indicative of very different underlying problems. For example, several students are reported for excessive absences, with consequent drop in grades. When attending classes, they appear uninterested and apathetic. Careful study is made of each student. In one case we find that the apathy is in reality a fatigue due to thyroid deficiency and that, as a result, the student finds it hard to "drag around" and get to classes. In another case, we discover a lack of ability to cope with that particular subject matter and the discouragement and lack of satisfaction show up in absences. The unacceptable behavior in another student is an expression of resentment at a vocational goal dictated by parents and the seemingly bored attitude is a preoccupation with conflict between loyalty and antagonism toward those parents. Financial worries, leading to a heavy overload, and marital discord account for the frequent absences in still another case. A fifth student has never learned to organize himself on an adult level and take responsibility for himself. He is easily distracted into pursuits other than those offered by the classroom.

The symptom—the reason for the reference in all cases—is that of absence. The causal factors fall within the physical, mental, and emotional fields and in most cases belong in more than one field.

On the other hand, very different symptoms may be indicative of the same fundamental problem. Doris, Phyl, and Ben, because of lack of affection in family relationships, have a great need for a sense of belonging and a feeling of security. Doris is trying to meet that need by being in every social activity, to the detriment of her school work. Her *poor grades* are a symptom of her need for affection. Phyl, on the other hand, has withdrawn entirely from social contacts and is devoting every waking hour to her school work, hoping to exact recognition from her instructors—parent substitutes. Her *high grades* are symptomatic of the same need for affection. Ben

is spending money lavishly in an effort to buy the approval and friendship denied him at home.

The emotional need is the same in all three students, but the symptoms are different.

Another peculiarity of symptoms is the fact that the same symptom may be a normal reaction on one occasion and a sign of emotional disturbance on another. Nancy appears in class to-day somewhat rumpled and disheveled. Rehearsal for a play has kept her up late, her alarm clock did not go off, and the girl is "thrown together" for her eight-o'clock hour. There are other times, however, when after receiving letters from home, Nancy's appearance is symptomatic of her emancipation problem—a rebellion against too much supervision and dominance in a home where fastidiousness is a fetish.

It behooves us, therefore, not to make snap judgments on the basis of a single symptom or behavior manifestation, nor to arrive at a diagnosis without a thorough investigation of *all* possible factors and interrelationships.

At the same time, it is important to realize that symptoms of emotional maladjustments may be found in any area and that frequently the student himself is not conscious of the real problem.

Physical symptoms are very often an indication of emotional upset. We even have such popular expressions as, "She gives me a pain in the neck," or, "It makes me sick at the stomach," when there is no reference to organic disturbance. Fatigue, headaches, difficulty with vision, gastric upsets, and other aches and pains are only too frequently expressions of a sense of mental or emotional inadequacy or both, an inability to strike a satisfactory emotional balance. We should be able to recognize the possibilities lurking behind such physical symptoms. The differential diagnosis should be made by competent physicians and psychiatrists.

Posture and dress may also be a barometer to emotional states. The too meticulously dressed student may unconsciously be asking for help with neurotic tendencies. The sloppy student may be flaunting emancipation drives in our faces. The slump may be an indication of depression, of defiance or fear and anxiety.

Manner of speech or speech abnormalities may be symptoms worth investigation. Dave does not speak clearly. He

slurs his "r's" and lisps his "s's." Physical examination is negative. He has been attending speech clinic over a long period, but he still clings to his enunciation difficulties. His speech is in reality a residue of baby talk and a token of his unconscious unwillingness to give up an infantile dependence on his mother. He protests his eagerness to correct the lisp, but actually he cannot give up what it stands for.

Many of the symptoms demonstrated in the classroom have little or nothing to do with campus relationships or pressures, yet they interfere with class performance and healthy, normal social contacts. Such symptoms must be recognized as stemming from inadequate relationships within the home, and the emotional problems they create must be evaluated in terms of family. A student's rudeness to the instructor and irritability with classmates may be symptomatic of a struggle for adjustment at home. In Bill it may be a natural loyalty to the parents battling with a disturbing resentment at their hold on him. The repercussions are felt in the classroom. In Joan it may be a clinging to dependence on the family and a striving for independence. The conflict is expressed in the student-instructor relationship. In Kate it may express rivalry among brothers and sisters and insecurity on the basis of unfavorable comparisons. The hostility is vented on campus associates. These are all feelings that can be translated into behavior, transferred to the classroom as aggressiveness or withdrawal, overambition or lack of ambition, too high grades or too low grades, difficulty with concentration, and any number of other symptoms of emotional disturbance.

Conflict between the need for adherence to the standards of home and parents and those of "the crowd" the student goes with may be expressed by such symptoms as overactivity —*i.e.*, running away from the problem—or drowsiness and sleepiness—*i.e.*, shutting one's eyes to the problem.

"I don't know why, but I just have to be on the go all the time," says a student. That drivenness may be symptomatic of temperament—a manic personality; it may be a physical manifestation—hyperthyroidism; it may be running away from one's self and the need to face and resolve an emotional problem; it may even be the brand of gaiety that is a cover up for anxiety and depression. It is not always listlessness and

apathy that indicate a depression which can be a serious mood disturbance—even a prelude to suicide.

Symptoms of poor emotional balance in the field of social relationships may show up as too many dates or no dates; ability to get along with older people, but not with those of one's own age; ability to get along with the opposite sex, but not with one's own, and *vice versa;* ability to work by one's self, but not with the group; and so on.

By now you are probably saying to yourself that anything or everything "may be" a symptom of an emotional problem. That is exactly what I am trying to get across.

The important thing is to cultivate an awareness of every possibility, to develop a discriminatory sensitivity and an ability to discern what lies behind the symptom and why it is meaningful to the student and to his adjustment at an adult level. It is vital that we keep in mind the significance of the symptom in relation to *all* other factors—to the total picture and the prognosis. We must be sure that our attention does not remain centered on symptoms, however, but gets back to fundamental causes. The latter may lie close to the surface and be more or less readily recognizable and explainable. They may lie buried deep below the surface and call for patient, skillful tracing and reference to a psychiatrist, without precipitating a serious emotional disturbance due to probing.

Since there can be such a bewildering complexity of causes behind an emotional problem and the effects of a single cause can be so confusingly complex, what should be the goal of counseling?

An important goal is that of understanding the student and helping him to understand himself and accept that self realistically—its assets and limitations, its potentialities and opportunities. This is important because the picture of the self is generally the basis for the attitude toward others and toward the environment. It can contribute to emotional adjustment or maladjustment, depending on how true that picture of the self is. The self-feeling is a motivating power throughout life and, therefore, helping the student to build a healthy, realistic self-respect through understanding is essential to good adjustment.

Emotional balance is never static, but is a continuous process, and so another goal in counseling is helping the student develop that type of self-direction which will give him a mature

adaptability in meeting the changing needs of the self and the demands of the environment. It is helping the student grow in self-reliance and the ability to maintain or quickly to regain his emotional balance in the face of inner tensions and environmental pressures. Self-assurance and security are essential to emotional adjustment within the student and satisfying experiences and successful relationships between the student and his social milieu.

At no time is the purpose of counseling to remove emotional problems, but rather to help the student detect, analyze, and handle emotions and attitudes that inhibit learning and prevent social contacts and relationships.

At no time is the purpose of counseling to present the student with a set of "thou shalts" and "thou shalt nots" as a guiding chart, but rather to help him to develop motivation for his own self-direction and for the self-disciplines that take into consideration his fellow men as well.

At no time is the purpose of counseling limited to correcting existing emotional problems, but rather to preventing them, freeing the student physically, mentally, and emotionally to devote his energies to the business of learning and preparing to earn a living, as well as living adequately and satisfactorily as an adult individual and a member of society.

Success in the counseling goal is dependent in large measure on understanding and dealing with the physical, intellectual, and emotional make-up and needs of the counselor as well as the counselee.

Counseling is not a routine, but a vital, confidential relationship. We bring into every relationship our personal feelings and attitudes, the result of our own life experiences. It is imperative, then, that the counselor take stock of himself—his own personality and emotional balance, his flexibility, objectivity, likes and dislikes, his sense of humor, his ability to see and feel as the student, but not like the student.

When Betty Jo says flippantly, "I have no use for men," the counselor must have the sensitive ear to hear that underlying, "I have no dates." The counselor must have the understanding heart to sense the reason for and the meaning of the hurt to that particular student. He must have the trained mind to analyze and put together into a meaningful whole *all* pertinent factors. He must have the steady, guiding hand to lead Betty

Jo into paths of self-evaluation that can help her realize that her infantile attachment to and idealization of her father are making normal relationships with young people of her own age difficult and retarding her own growth process. The counselor must have the insight and wisdom to take that next step which will help Betty Jo want to put into living practice her newly gained knowledge and understanding. And throughout it all, the counselor must see himself objectively in relation to the student and his problem as they move forward step by step.

If the counselor is judgmental in his attitude, it does not leave the student free to express himself and to strike an emotional balance by being given a chance to voice an explanation of his own problem freely and to formulate a solution. The counselor must be willing and able to serve as a sounding board rather than as the voice of judgment. Not by words alone does he express his attitudes. A slight lift of an eyebrow passes judgment as clearly as, "You should have known better."

Gwendolyn is reported for cheating in English. She has handed in as her own composition a story copied out of an old magazine. Judging her behavior solely on the basis of breaking classroom rules and regulations would call for discipline which in her case would only create a greater problem. The counselor needs to understand Gwendolyn as a girl with average mental ability, but with parents who expect her to do A and B work because her sister did. The counselor needs to see her as a somewhat ungainly, retiring adolescent, whose family is constantly comparing her with that attractive, outgoing sister. The counselor needs to appreciate the lack of satisfactions in this student's life and her intense drive for acceptance into a sorority, which depends on her grade in English. Understanding gives an entirely different slant on the situation in which Gwendolyn is trying to meet very basic emotional needs for belonging and acceptance, recognition and approval by her own age group, as well as that of the adults of importance to her. It is not through judging, but through complete and sympathetic understanding that the counselor can help Gwendolyn strike a healthy satisfaction-giving balance between her emotional needs and her manner of meeting them.

The counselor must be willing to begin at the point of the student's understanding and readiness and move forward with him, at his pace, in a coöperative quest for a solution of the

problem acceptable to the student. When Jim comes with a statement that he is "all fouled up financially," it may be easy for the counselor to see that the low state of the boy's finances is in reality an emotional problem—the outcome of immaturity, insecurity, and earlier lack of opportunity to carry responsibility. The counselor, however, must start with the immediate financial situation, in the meantime laying the ground for Jim's understanding and acceptance of the true causal factors. The counselor himself must be alert always to the interrelationships of problems and be able to evaluate their bearing upon one another and the total situation.

The counselor must be able to differentiate between serious emotional maladjustments and personality difficulties which call for psychiatric treatment and the milder problems and potential maladjustments with which he can deal. The willingness to release the student and the ability to refer him to the right person, at the right moment, in the right way, is an important faculty.

It has been said of counseling that "you learn and learn and learn and what remains to be learned grows and grows." It can be no more truly said than of counseling with emotional problems. It is a tremendous challenge, for as you learn, you, too, grow. And the willingess to learn and to grow is of paramount importance in emotional problems and in the counselor-counselee relationship.

PSYCHOSOMATIC MEDICINE: CLINICAL AND RESEARCH IMPLICATIONS *

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PSYCHOSOMATIC medicine has many implications for the trend of medical education and practice, as well as for the welfare of mankind as a whole. From the very beginning of his medical career, the student should study the origin and direction of flow of man's psychic energy. All our studies of individuals with psychosomatic diseases show (1) that large quantities of superfluous or misdirected emotional energy, such as anxiety, rage, hate, longing, are acting upon them, or through the body or a body system, and disturbing the normal physiological activity; or (2) that a body organ, a system or part, is symbolizing an emotional problem with such intensity as to impair normal physiological function. Since this state of affairs makes the individual ill so often, it is obvious that the doctor must know a great deal about the many ramifications of this psychic energy in order, first, to understand the illness; second, to institute treatment; and third, to act as an educator in helping prevent such disorders.

There are too many people going about the world crying, hating, fearing, or longing for something. The haters we have long known in the form of the delinquent in court or jail, or possibly that of the truculent, hard-to-get-along-with ordinary citizen. But we still have not become used to seeing him in the case of hypertension, migraine, or gastrointestinal disturbance. We see around us every day people who seem to like a great deal of attention, but we have not estimated correctly the great depth of longing to be taken care of in the depressed patient with aches and pains, the alcoholic, the drug addict, the neurasthenic, the hysteric. We can picture understandable fear situations in the face of danger such as fire, explosion, collision, war, but we do not yet fully understand how much

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fear a woman can have about being pregnant or having a baby, or a man may have about losing his income or status, or any one may have about an illness that does not exist. As for crying, there are many people ill with psychosomatic illness who are suffering from very deep unhappiness. Some of them actually cry easily, while others would rather suffer the greatest distress physically than admit that they are unhappy. Their symptoms cry for them and their behavior bears witness to their helplessness. They cry inside and do not realize that they are crying.

The doctor must know about these emotional energies that get misdirected into man's organs and tissues, but he must also know why they are there, exerting a harmful force. This is because they were never properly handled in childhood through training and education. The love needs were never met, and the hate and fear were never neutralized. The crying was never stilled when this could easily have been done. Left to themselves, these emotions grew wild, so to speak. The unsatisfied demand remained. The hate and the fear had to attach themselves to some object. These people never learned to work and love and create happily, and so we find these undomesticated energies or these unchanneled energies working toward producing a sick body, instead of being used constructively in social and personal ways.

To detect these emotions is not always easy, and it calls for some prolonged study of the personality. Emotions can be hidden behind character traits, which act as defenses against the ego's revealing itself or being revealed. For instance, hate may be concealed behind diffidence and politeness. Great need for protection may be compensated for and hidden behind great endeavors for others. So we must not be content with what we see on the surface.

All this takes time to teach the medical student, the interne, or the resident, and in turn it takes time and skill to teach these things to the patient. There are three omnipresent resistances to psychotherapy in our culture at the present time. They are (1) the pain of self-revelation, (2) the time, and (3) the money necessary to effect changes in personality. So far as the last two factors go, there seems little chance of a change for the better at the present time, and the first will change very slowly. This means that we must have excellent

understanding and great skill in passing this understanding on to the patient and helping him to use it, and we should have an enlightened public as well.

No patient can operate upon himself surgically, nor can he diagnose and treat his glandular, infectious, and neoplastic illnesses. But he can know as much as possible about the functioning of his personality. Knowing this makes him not only a more coöperative patient when he has a neurosis or psychosomatic illness, but it should make him a better husband or wife, a better parent, a better world citizen, and a more useful diplomat or politician.

Recently at a meeting in New York on social medicine, Dr. Henry Sigerist said, "The doctor is now becoming the adviser to the statesman." This may not be happening to any large extent at the present time, but certainly, if we doctors know our business as we should, it is not a presumptuous statement. No country as a whole wants poor leaders or poor leadership, and yet this is what a nation often gets because its people do not know how to discover and to elect good leaders. There is a relationship, therefore, between a doctor's knowing well the personality make-up of his patients and a community's or a nation's knowing more about those who plan and execute its destiny. Until man has a better understanding of himself, he will never understand others. Group behavior will never advance for very long beyond the degree of progress of the individuals that make up the group. The doctor must take over the rôle of educator more than he has ever done before in the history of medicine.

The Difference Between Neuroses and Psychosomatic Diseases.—The question often arises as to where the psychosomatic diseases stand in relation to our original concept of the neuroses. It would probably be difficult to get unanimity of agreement on this. In the first place, we would say that, with the exception of a few compulsion neuroses, the neuroses are psychosomatic diseases. What we have been doing in the past twenty-five years is to add to our list an increasing number of conditions in which emotional factors play a reasonably large rôle.

Some would seem to limit this group as the only disorders worthy of being called psychosomatic disease, as if the neuroses of our original classification were conditions of simple

dynamics, easily cured and hardly worth our notice, as compared to a case of mucous colitis, asthma, or hypertension. There is no getting around the fact that there are a great many people going to doctors' offices who are suffering from anxiety hysteria, nearly as many suffering from neurasthenia, and fewer from conversion hysteria. Furthermore, these cases are not so easy to cure; they require much patience and skill, and if not cured, they become a great expense to society. The fact that some cases involve the body more tenaciously, more chronically, and perhaps more violently and are called psychosomatic diseases rather than neuroses does not mean that the difference between the two may not be only one of degree—of quantity rather than of quality.

Let us take, for example, a case of periodic dyspepsia occurring at a time of emotional tension, and contrast it with a case of duodenal ulcer. In both cases similar mechanisms are presumably at work, both psychological and physiological. Both are psychosomatic phenomena, but one must work more continuously, and with greater intensity, than the other. Why should there be this difference? It would seem from clinical observation that the case that progresses to ulcer formation is more psychopathological in the following ways: As pointed out by Alexander and his co-workers,[1] there are passive needs for love, attention, and security. But in addition to having these needs, the patient also lacks the necessary techniques for finding these things for himself in a world that improves for him as he grows older and offers them to him if he only knew how to accept them.

This seems to be because the primitive emotive part of the mind has never been exposed to and become used to friendliness in early life. It remains cold, suspicious, aloof. When thrown into contact with school comrades or work colleagues, such a person misses the friendly part of these personalities and sees and feels too much of the negative and unfriendly part. He cannot forgive a slight; he grieves at lack of attention; he feels lost and isolated in a crowd. His growing dissatisfaction with life prevents him from finding the soothing value of friendship. The brain (the

[1] In a symposium on "The Influence of Psychologic Factors Upon Gastro-Intestinal Disturbances." *Psychoanalytic Quarterly*, Vol. 3, pp. 501–39, October, 1934.

mind part of the brain) is an inadequately functioning organ.

Just as the person who eventually becomes psychotic fights a losing battle with a pleasant hold on reality, so the serious psychosomatic case has the same difficulty. He differs from the psychotic in that he maintains a conventional relationship with society. But in his private mind he suffers, and his struggles to find a richness in life are greater than in the case of the neurotic. This would seem to be because the eventual psychotic and the serious psychosomatic case—and, for completeness of description, many delinquents—have suffered a great affective deprivation in early life which has undermined their capacity to adjust.

There are certain personality characteristics that it is most important to acquire early in life. One of these is the ability to tap the warmth of other people; another is the development of various techniques for meeting disappointment and frustration; a third is a basic trust that the good will of most people can be obtained if one works hard at it; and a fourth is recognition by the individual that he needs the friendship of other people and the ability to use it when he finds it.

These characteristics generally develop naturally in the home of well-adjusted parents, and yet many factors in modern life have contributed to modify this environment which still bears the name of the "normal" home. The home is smaller and there are fewer people to care for the baby. Young parents want more freedom and the infant has less contact with them. Women have been going through an era of conflict between motherhood versus career. Doctors have often discouraged the mothering that the infant needs for security and for learning about the value of warmth. So the psychosomatic case has a psychic defect which makes itself known in symptoms rather than in delinquency or psychosis. The less severe forms of psychosomatic affection are called neuroses.

This sounds ominous or like putting the psychosomatic case into bad company, but if this relationship is true, we should face it for clarity in thinking, and, besides, we are all bravely trying to face the facts of mental illness. The term "psychosomatic" has undoubtedly contributed to an acceptance of psychiatry, since it took body illness as the

starting point and brought in the emotional cause secondarily.

The Doctor as Educator.—If these are the defects of the psychosomatic case, then certain specialists are in an excellent position to prevent their occurrence, or at least their perpetuation. The pediatrician, for instance, is in a wonderful position to make clear to the mother the emotional needs of her child at all ages and to supervise within the family the optimum conditions for emotional growth. No one group of equal numbers could do a more effective job of mental hygiene than a well-informed body of pediatricians who understood the needs of the personality. A word or two from the pediatrician on the baby's needs during the nursing period, on the value of patience, kindness, and no undue hurry in the toilet-training period, of a calm acceptance of the phenomena of childhood sexuality, and of a balancing of the interest of the mother and father in the child's development—a little time spent on these things in the right period could save much trouble later.

The internist and the general practitioner take up with the patient where the pediatrician leaves off—in fact, in many instances the general practitioner has been the pediatrician. There are many ways in which the doctor can educate the patient into logical thinking about body functions. People acquire many conventional delusions about "foods that are bad for them," or the necessity of one or more bowel movements daily, or the significance of weighing too much or too little as an indication of "gland trouble." In other words, there is a valuable preventive psychology to be exercised before one encounters the patient who has a cancerophobia or who is convinced that each hour is going to be his last because of vascular hypertension.

The obstetrician, the gynecologist, and the genito-urinary specialist are in a position to allay many fears and to correct much misinformation about the sexual and procreative functions. The endocrinologist and the allergist have a great responsibility at this phase of medicine to separate allergies and glandular factors from the interrelated factor of emotion. In the past many have followed the lazy way of ignoring the emotional factor and consequently limiting the good that they could do their patients. The dermatologist has been one of the earlier practitioners to become alert to the pos-

sibilities of the emotional factors in his field of practice. The gastroenterologist gets the later life results of many emotionally undernourished, hostile, and ineffectual people who are expressing their emotions through disturbed bowel function. A very large number of gastrointestinal disturbances are emotionally conditioned, and education is a most important part of therapy.

So we see that psychosomatic medicine carries the implication more than ever before that the doctor must assume the rôle of educator on a large scale, instead of being merely a drug prescriber or a technician. He does not need to give up these latter functions, but he must take on the former as well if his patients are to find health.

Research Directions.—In the field of psychosomatic medicine, the needs and possibilities are almost limitless. We have hardly scratched the surface.

Research could be divided roughly into three categories: research on emotions themselves; research on the neurophysiological system as the transportation system of emotions from psyche to soma; and research on the somatic end results of psychosomatic disease.

In the realm of emotion, we need more observation of young infants, to determine how much and what kind of care is necessary to give the minimum peace of mind necessary to healthy physiological functioning. We could give a group of children the most and the best we know in natural and paternal care and freedom from conflict. This group could be compared year by year with children who had received average care and those who had been subjected to definite deprivations. This would come closer to a scientific study than anything yet attempted in the way of measuring emotion.

In research on the neurophysiological system, we need more work by doctors trained in neurophysiology who also subject their own emotions to study for a long period through psychoanalysis. Then they should get together and give us the benefit of their thinking on cerebral localization and the flow of psyche energy. We could think more clearly about the problems of psychosomatic medicine if we had some theories on the neurophysiological system as the system of energy distribution. For instance, in acute or chronic tachy-

cardia, are the accelerator fibers overstimulated or are the inhibitory fibers failing to function? And what is needed at the psychic end to bring about equilibrium? In regard to the overacting gastrointestinal tract, the same question is unanswered—why the activator fibers predominate and the inhibitor forces fail to retain an equilibrium. Theories have been found so useful in the realm of physics and psychology that it seems very necessary to effect some combination of them for a clearer explanation of symptom formation.

Finally, there are a host of studies that can be continued on the soma under conditions that will show the effect of emotion on blood flow, on lymph flow, on glandular function, on the activity of unstriated muscle, on vascular tonus, and so on. In fact, the medical research of the future must take into account to an ever-increasing degree the effect of mind upon body function.

CHARACTER DEVELOPMENT OF THE GIRL FROM SEVEN TO FOURTEEN *

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THE Girl Scout movement is a natural development in the evolution of woman's place in the world. Physically weaker than the male and by primitive parts of her nature prepared by deep, passive capacities for self-sacrifice, the woman has until recent times accepted a subordinate place in the affairs of the world. In the memory of living men, her legal status has been not far removed from that of a possession of the male—subject to his mood or whim.

Woman's genius for creation, inherent in the deep biological drives of motherhood, could not forever lie subordinate to the aggressive drives of the male. The male glories in competition, whether in the field of work or in that of armed combat. These masculine drives have determined in no small way the existence of war and other social evils that have punctuated history. The need of woman for peace and justice lies in the deep sources of her instincts. Peace and justice she needs for best functioning as a mother. Your female ancestors have, over the course of milleniums, curbed the savage drives of the male, so that we generally are fairly peaceful in the home. This is not true of the male at large in the world of to-day, as evidenced in his international relationships.

Sympathy, tolerance, self-sacrifice, which lie behind the concept of a true and universal love taught by all modern religions, are derived largely from the female soul, as one of the highest expressions of her primitive creative drives. By her domestication of the male in ages past, it has become possible for him to add his strength to the woman's in providing a better and more stable environment for children to grow in.

* Presented before the Westchester County Girls Scouts Institute, April 14, 1948.

We are now facing, in this atomic age, dangers not only to the home, but to the very existence of humanity itself. Woman, the source of life, must reach for a new place in the world if this tremendous man-made force is to be diverted from destructive into creative channels.

As Girl Scout leaders, you have an opportunity to direct the developing girl toward a full realization of her capacities as a mature woman. The home has always needed the woman. Now the world cries out its need. That the rise of woman suffrage has coincided historically with the development of social reforms in our national legal structure is no accident. The advent of women into international politics, as exemplified by one of our representatives in the United Nations General Assembly, is a real advance in the direction of world peace.

These remarks are made to emphasize the fact that you here are not dealing just with Brownies and Girl Scouts; you are dealing with a future generation of women who will need to be prepared for challenges that perhaps never existed before in history.

As I understand it, the great majority of girls in Scouting are in the age group between seven and fourteen, and Brownies "fly up" at the age of ten. In this span of seven years, the girl, developing in an average way, passes through three stages of development. The period of from seven to ten represents the end of the childhood period; from ten to twelve is a transitional period between childhood and puberty; and from twelve to fourteen is the period of puberty itself.

This grouping is by no means an entirely arbitrary one. Girls tend to distinct patterns of behavior, determined by a definite physiological and anatomical evolution coincident with these three age periods. It must be remembered, however, that the rate of physiological and personality development is not necessarily the same for all girls. Some girls menstruate at eight or nine, others not until sixteen or eighteen, and personality characteristics related to this sign of maturation will thus develop earlier or later than the average in individual instances. So the age periods of seven to ten, ten to twelve, and twelve to fourteen of the child, the pre-puberty, and the puberty girl, are but statistically

valid concepts applying to large groups; they may or may not fit the individual.

Let us consider the Brownie, the child-girl between seven and ten. By seven a girl has had much experience already in living. She has by this time faced in infancy and early childhood the free-for-all and selfish competition with the boy. She has had to face and struggle with the humiliating realization that she is physically inferior to him. She is not yet aware of the feminine side of her nature, which can enjoy passivity and being subordinate. This element of her being blossoms through adolescence and flowers in adulthood into the great and unique capacity the woman has for self-sacrificing love.

The Brownie, more of a boy-girl than a female, hides her hurt feelings by rationalizations that boys are made of "snips and snails and puppy dogs' tails" and are "too rough, anyway," by ignoring them or by teasing them at a safe distance. She begins at about seven to develop—and she needs to develop—close pal relationships with her own sex. The Brownie program, therefore, satisfies real personality needs in the seven-to-ten-year-old girl.

Infancy and childhood are periods during which the muscular system is developing and demanding expression in activity. This activity must be realized if the adult woman is to develop the physical poise and gracefulness derived from the sure knowledge of the function and use of her body. For the Brownies, this suggests the need of a program in which active and competitive games play a large part and interrupt frequently more sedentary occupations. Outdoor activities in which the noise and exuberance of the healthy child-girl can have free expression should be provided. Don't try too hard to make ladies of your Brownies. They are not prepared yet by nature for this stage of development. I do not mean to suggest that essential elements of hygiene, such as cleanliness, should not be a part of your program, or that the Brownie should not be led into social patterns that will help her to get along in a group with other children.

This is also a time to prepare her for one of her later functions—that of homemaker—by helping her to learn to be helpful with domestic chores. She should be exposed—as you, of course, see that she is—to nature in its various mani-

festations—trees, flowers, rocks, animals, and birds. Overnight camping expeditions under the guidance of a motherly person can start the gradual emancipation from mother that the girl must eventually achieve if she is to take her place in the world as a full woman.

On her entrance into the Brownies, the seven-year-old has had close and intimate contacts with parents and other parent figures, such as relatives, older family friends, and her teachers, who have acted as models for her. These will be the background for the patterns of behavior with which she meets the Brownie group. The maturity and wisdom shown by these parents and parent figures will determine in no small way her personality.

Parents who are mature themselves will have already taught the Brownie the value of sharing and will have eased her adjustment to the group. On the other hand, oversolicitous mothers, burdened by unresolved anxieties of their own, will leave a legacy of helplessness and infantile cravings to the Brownie. According to her temperament, will her response be determined. The more passive and sensitive child of such a mother will wait silently, though perhaps sullenly, for the ministrations of the leader. She will show inadeptness in the use of her body and be clumsy in games and handicrafts, as she has not developed, through doing, the finely coördinated capacities inherent in her body. The more aggressive child, finding herself in a group without the hovering ministrations of her mother, may indulge in temper tantrums when thwarted, or make problems by her mischief and other attention-seeking activities. These girls are crying out for help and must be treated according to their psychological, not their chronological, age. They will need special attention and consideration at first.

Some Brownies come from homes in which there are many children and the mothers have little time to give each the personal attention that all children crave and actually need for their personality development. These children may yearn for affection. It is often in this love-starved group that one finds the Brownie who fawns on the leader.

Let your feminine intuition respond to the need of these children and help provide them with the demonstrative love that will strengthen them so that they can one day achieve

independence. Such children do not necessarily come from homes of large families. Some parents have not reached full personality maturity and sacrifice their children to their own needs for social and recreational life, leaving their offspring either in the care of domestics or on the town. Such children may need occasionally to be cuddled and fondled on the leader's lap like an infant. The real woman will recognize these children and meet their needs, and by wise guidance help them find more independence.

All of you Brownie leaders have faced the problem of the hyperactive child. Here, again, the leader should approach the problem with the attitude of one who first of all seeks to understand rather than of one who must establish her authority and thus seek to discipline. Is this child inhibited at home by parents or at school by teachers who are going by the old maxim, "A child should be seen, but not heard"? Fatigue and ill health in certain children are stimulating and lead to hyperactivity. A child who feels unwanted and unloved by parents and playmates may express in overactivity his need to gain the notice of others. These infantile patterns, normal to the two-to-five-year-old, are a sign of immaturity in a child of Brownie age.

Energy is our fundamental and most precious possession. It is your problem as leaders to find suitable and constructive outlets for the energetic child. What positive abilities does she have? A child of average intelligence has something she can do, or has the capacity to learn something she can do, a little better than most others. It is by learning of our capacities and perfecting them that a person gains his place as an individual in the group.

This drive for a place in the limelight lies deep within all of us from early infancy. It is part of your responsibility as leaders to help your girls find something that they can do best, so that they can add to the welfare of the group and thus find their place in it. With those gifted with healthy aggressiveness, intelligence, and special skills, you may have no trouble. But what about the timid and sensitive child? They may present no obvious problem. They do not disturb the group by noise and other attention-seeking devices. They may follow, perhaps too well, the suggestions of the leader. Because they may make no errors, does not mean they

are making any hits or runs. Are they achieving any real individuality? These girls can be easily overlooked in favor of the more aggressive girls who may actually need little of your help.

The quiet and sensitive child demands great patience and understanding from the leader, to tease out from her the aggressiveness and capacities that she is hiding. It is upon this group of sensitive individuals that the world has always depended for outstanding gifts of true creativeness in the arts and sciences. They are different. This difference sets them apart, but they must learn to express themselves if they are to be productive. The average person is often tied down by common conventions of thinking and feeling and acting. He is the salt of the earth and the strength of a democracy. But it is from those who are different from the average and not bound by the conventional that new and finer vistas of life come, through which our civilization advances.

Some such children have gifts that are great, but that may be highly specialized. To expect such girls to get ten badges and become First-class Scouts may be unreasonable and only a confession of rigidity. They may need to concentrate in one or two program fields for the best expression of themselves. These girls—rare, to be sure—should not be overlooked and should have some special recognition of their talents, even though the reward of becoming First-class Scouts may never be realized.

In the age period when the Brownie becomes a Girl Scout, she starts a period of physical and personality development which, by thirteen or fourteen, makes her as different from the Brownie as if she were a distinct species of animal. The lovable, but dirt-streaked Brownie, active and noisy, at ten may begin to go through periods when she is poised and full of decorum—critical of her tomboy sisters, only two minutes later to be rolling on the floor in a wrestling match. She surprises by displaying periods of preening before a mirror, expressing interest in cosmetics, hair-dos, and she has many fads about clothes. Long and secret conversations with best girl friends and tendencies to involved day and night dreams concerning the mysteries of sex become an increasingly important part of her life. Yet she is not pre-

pared to use her energies efficiently, or for her own good toward adult sexual goals, and much of this awakening drive needs sublimation in other activities.

In this age group interest in active pursuits lessens. The miracle of approaching and developing womanhood ebbs and flows in her body and makes increasing demands upon her life force. Sports and hikes may be resisted as nature expresses her recognition that energy needs to be conserved for something more precious now than the development of muscular coördination. The budding of her womanhood, with the change in her body structure, may lead to a noteworthy lessening of her physical adeptness. Concentration and attention span is lengthened, however, and she is ready for more complicated projects, though she may at times bewilder the leader by her variability.

The young Girl Scout is now becoming increasingly interested in the opposite sex, but she hides her interest, except in so far as she compares notes with her best friend in secret. She maintains a disparaging attitude toward "the boy" or else denies his existence, but her own developing body attests to the falsity of her pretended attitude. Girls of this age love to talk and whisper among themselves. They may surprise or even shock the unsophisticated leader if she overhears their secrets, though ordinarily the pre-puberty girl is too careful to be overheard.

Her inconsistency, her half-formedness—neither in childhood nor in puberty—is a source of great annoyance often to her older Scout sister who has entered the period of puberty, so that separate programs under different leaders are often advisable. In certain Scout groups the advisability of making two completely distinct groups may need to be considered. The pre-puberty girl is the uninitiated. Her older sister is a younger member of the ages-old sorority of womanhood, and as such she feels superior to and annoyed by the impulsive childhood responses of the younger Scout.

Overnight camping trips should be a distinct part of the program for the Scout group. Here there will be opportunity to compare notes about the secrets of life. The girl should welcome the opportunity to escape from mother for a short while, but she will at the same time often display her fears of this emancipation by the disorganization of her preparations and a hectic last-minute rush for forgotten,

but necessary equipment. On camping trips, arrangements should be made for periods of free time in which the girls can just talk among themselves with the very minimum of supervision.

Giving expression to what one day will be the strength of the adult woman may result in rebellious attitudes, in the individual Scout or in the group, to suggestions made by the leaders. This need for self-expression, this feeling out of the girl's own power, is not to be misjudged. Often it should be tolerated by the leader. The leader who is wise will see beyond the rebellion into the girl's attempt to free herself from childhood ties to mother figures, so that she can achieve one day her independence as a mature woman. The understanding leader will carefully choose her method of handling the situation.

The older Scout, going through puberty, marches beyond her pre-puberty sister. She is not so much concerned now with curiosity about the facts of sex, but is beginning to be consciously aware of increasing strivings for expression of her instinctive drives. In this stage she is not only fascinated, but she is also frightened by this sudden surging of her instinctive strivings. These girls need leaders who have achieved a full maturity of personality development, leaders not inhibited by puritanical or poorly thought out moral codes; women who have experienced the fullness of stable relationships in marriage and motherhood.

It is at this stage that discussions about make-up, styling in clothes, social behavior, should take place under the guidance of a wise leader who will not lecture, but will help the girls think through the rationale back of what is proper. The girls should participate actively in such discussions, in which they can often ventilate their concerns and fears and achieve real understanding. Social dancing classes and parties in which boys are included can often be introduced at this time with benefit. Physically active pursuits at this age should begin to play a minor rôle in the Scouting program. Body development at this period demands a great proportion of the life energy. However, picnic hikes in which boys are included will often stir up a great enthusiasm.

The girl at this age should be achieving gradual emancipation from childhood daughter-parent relationships. If she has the opportunity, she may surprise the leader by the

intimate questions concerning sexual topics that she asks. It is not natural nor necessarily even healthy for the developing girl of this age group to take up all such questions with her mother. She may need to check up on mother, for by this time she is beginning to be aware that mother is not infallible. The leader should realize that such curiosity is natural and healthy and she should be prepared to handle such questions tactfully and honestly.

We too soon forget the doubts and fears that beset us in puberty. Recent research into the behavior of the girl in puberty has indicated the common presence of much thinking and phantasying of a sexual nature surprisingly adult in their context. We are prone to blind ourselves by thinking of the child and the adolescent as innocent, by which we often mean without sexual curiosity or urges. Our culture, as perhaps no other, has been much too unrealistic and naïve in this respect.

Your thirteen- or fourteen-year-old is becoming a woman and is beginning to experience, in dreams, phantasies, and feelings, drives toward mating and motherhood that are inherently a part of her womanness and, as such, natural and good. However, she is not prepared to accept the responsibility for such full adult functioning and needs for some years yet to sublimate much of her instinctive drive in related activities. Working for badges in such fields as child care and hostessing should interest her.

Programs that include boys are best tolerated by both sexes if they include active and competitive games in which boys and girls can be on the same team. By working on one team together, they learn the value of coöperation and where the strengths as well as the weaknesses of each sex lie. In competitions in which running is important, the boys will as a rule be superior, but in games that demand subtly coördinated skills, the girls will usually win out.

But, above all, the older Scout will have this in common with her younger sister—she will love to eat. To have a group of girls working for the hostess badge at all times, so that parties can regularly punctuate the Scout year, should pay dividends in keeping up interest in the whole Scout program.

As leaders, by your interest in Scouting you attest to your own maturity and add to your own personality growth

through meeting the challenges of this position. The mothers of many of your Scouts will need the benefits of your trained and matured judgment. All Brownies and Scouts do not easily achieve good group adjustment. In all probability the real source of the problem of adjustment will not lie in the girl, but in the parents. The recently organized Trefoil Club in White Plains, New York, has given leaders a good opportunity for making contacts with the mothers of these girls and learning the real background of their difficulties. With this understanding, the battle is half won. The continued development of such clubs should be of distinct advantage to Scouting.

The Girl Scout should grow beyond Scouting, in the usual sense, in her very early teens. Those who remain interested should be a source of intelligent concern to the leader. What are the motivations of these girls and are they healthy ones? Are they trying to cling to girlhood, thus really only dodging the responsibilities of adolescence? The older Scout, with her long experience, may well be of distinct help to an overworked leader who will have selfish motives for encouraging her to remain in the Scout group. By this encouragement the leader may only be fostering a continued close, mother-daughter, dependent relationship which will stunt the girl's personality growth toward true womanhood. Most girls who are growing in a natural way will gradually drop out during the years from thirteen to fifteen, having gained what they need from Scouting. These girls are probably ready to try out their knowledge and skills in less formally organized groups away from the supervision of mother figures, including the Scout leader.

To many girls, Scouting is of childhood, and like St. Paul, these girls believe, "When I was a child, I spoke as a child, I understood as a child, I thought as a child. But when I became a woman, I put away childish things." Scouting is an important constructive and productive interest for the developing child. It plays its greatest rôle in what is but a phase of the child's progress toward maturity. You leaders, as mature women, I am sure can let your girls pass out of Scouting into life without bitterness or self-pity, just as you will let your own children leave your homes for the world with pride and happiness.

THE PASTOR'S USE OF CREATIVE LISTENING*

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THE first principle of the doctor is: *Do no harm.* That should be the first principle of the clergyman also in his pastoral work. We must do as the doctor has done through the generations; we must work as best we can with our present understanding of our task, taking care to do as little harm as possible, knowing that God through nature is working on our side. At the same time we must strive to increase our knowledge and understanding of human personality and behavior.

A famous pastor has given us the story of a girl who came to him, saying, "Doctor, I want to talk to you about my lack of belief in God." The pastor said, "Tell me first about that love affair." His insight was excellent; his method was poor. He moved too fast. The girl's reaction was certain to have been, "My God, is it that obvious!" Good pastoral work does not shock the parishioner; the risk of doing harm is too great. Hence the importance of sound methods which temper insight.

In my early days as chaplain at the Massachusetts General Hospital in Boston, I went about seeing patients who were suffering from various diseases. Because I did not know what to say—and had little chance to say it even if I had known—I kept quiet and let the patients talk, which they did readily enough. They talked about themselves and their suffering; they talked about their families and homes, and sometimes their lack of family and home; they talked about their jobs and their bosses, jobs they had done and other jobs they hoped to secure; they talked about places they had been, people they had met, books they had read, and sometimes books they had written or hoped to write; they talked about sports, baseball, hockey, prize fights, and

* From the forthcoming book, *Pastoral Work and Personal Counseling,* by Russell L. Dicks. Revised edition. New York: The Macmillan Company.

football; they talked about their churches and their ministers; and again they talked about themselves, their loneliness, their fears, their frustrations, their beliefs and lack of beliefs; they talked of death and of dying—their fear of dying and their eagerness to die. These patients had been strangers but a brief time before; now they talked willingly, readily, frankly, and eagerly. When I rose to go, they thanked me for having helped them. They did seem to have been helped. When I asked myself what I had done, the answer was obvious: I had listened.

Psychiatrists, psychoanalysts, and social workers have talked of listening. The ancient church made it a Sacrament. Little has been said of it among the free churches since the Reformation. Our clergy have spoken of themselves as "called to preach," by which they have meant proclaiming the gospel, pointing the way. Preaching is preacher-centered, while listening is parishioner-centered. Listening means that the sufferer selects the topic of conversation, raises questions, seeks for the answers. Listening means working with a parishioner where *he* is in his soul's journey, not where the pastor is. Listening means patience and courage and trust in the universe of which we are a part. Ministers are usually poor listeners; they have not mastered the art of listening because they have been so on the defensive and because what little instruction they have received in the practical field has been in the art of preaching, which is the opposite technique of that which makes for effective pastoral work—namely, *listening.*

Underlying listening are three conditions: suffering on the part of the parishioner; rapport, which is probably the most important single factor in helpful pastoral care; and the maturity and personality of the listener. Recognizing these three underlying conditions of listening, let us move on to describe it more specifically as a method.

The first time I wrote upon this subject was in *The Art of Ministering to the Sick.* Since then various other authors have written upon the subject, calling it by various names: Garrett, in *Interviewing: Its Principles and Methods;* Rogers, in *Counseling and Psychotherapy;* Bonnell, in *Psychology for Pastors and People.* Dr. Carl Rogers has attracted wide attention with his description of what he calls "non-directive

counseling," and we owe him a debt of gratitude for giving us a corrective against aggression, which is the tendency of every one who learns to ask questions. At the same time I would maintain that there is no such thing as *non-directive counseling,* for there are many ways of being directive without asking questions. Professor Hocking has said, "All conversation tends to transmit philosophy, since no one can express an idea without conveying, if only by a flick of the eye or a gesture, something of his general temper and outlook, his optimism or pessimism, his belief in intangibles or his hard-headed practicality, his self-centered disdain or his liberal sympathy."[1]

Further, I would maintain that it is the *permissiveness* that exists between the pastor and the parishioner, rather than whether one is directive or not, that is important.

The first phase of the Listening Ministry is *directive listening.*

Directive Listening.—Directive listening is characterized by the use of questions by the pastor. What the scalpel is to the surgeon the question is to the pastoral counselor, and it is quite as dangerous. The good surgical operator is one who knows what to cut and what not to cut, and who has a knowledge of time; the good pastor is one who knows what to ask and what not to ask, plus a feel for timeliness. The pastor who asks questions too rapidly is like the surgeon who cuts into an abdomen too fast.

The art of pastoral work and counseling is the ability to know which questions to ask, and when. Through the use of questions, we express our interest in a person, we explore his spiritual condition, we relieve suffering, we reveal and aid in the gaining of insight, we release new resources, we stimulate new efforts. The art of asking questions is a significant part of the art of pastoral care.

I discovered something about the use of questions in a state mental hospital while I was still an undergraduate. Shortly after my return to the seminary, a new student, who had returned to finish his preparation for the ministry after spending eight years in business, came to my room.

[1] See *Types of Philosophy,* by William Ernest Hocking. Revised edition. New York: Charles Scribner's Sons, 1939. p. 5.

He said, "I heard the boys say you have been studying psychology and counseling. I need some help."

We went to work in the way I remembered the psychiatrists had gone to work, asking questions. I asked him why he had left the seminary eight years before, why he had returned, why he had gone into business, how successful he had been in business, why he got married, whether he loved his wife, whether they were happily married, why they had a child, and whether his wife was in love with some one else—all in less than half an hour.

At the end of that time, he jumped up and practically ran out of my room. I did not see him again for a conference for over a week, despite his acute need for counseling. That is the way we do harm when, through the use of aggressive questions, we have no consciousness of timeliness. Those were good questions, but they should have been spread over a period of several conferences, which would have given rapport and time an opportunity to heal the wounds.

Through the use of questions, we explore a person's spiritual condition; at the same time a relationship is developed and insight is gained by the parishioner. The baffling fact remains, however, that some persons are helped through talking about themselves, even though little insight is gained.

Directive listening is used when you are seeking to develop a relationship and to express your interest in a parishioner. It is used in routine calling, in counseling with youth, in the sickroom, with the bereaved, with persons who you suspect are having marital difficulty, though in this latter situation questions should be asked with care. It is used sparingly in office counseling, especially during the first call, for it is apt to carry one off into secondary subjects of discussion. Neither are questions used when the parishioner is talking well, unless you suspect that he is simply double-talking himself away from the subject. When a pastoral conference is going well and the subject is opening up nicely, even though there are tears and expressions of hostility, the second phase of the listening ministry is used.

Supportive Listening.—Supportive listening is what I have called elsewhere passive listening, but the term is not adequate for describing what actually happens. *Supportive* is

a term now in use by the psychoanalyst; *listening* is my own addition.

In supportive listening the pastor does just what the term implies: he emotionally supports the parishioner as he listens, thus centering attention upon the parishioner's thought and need and not upon something else—for instance, the pastor himself, or the church, or Christ. If the parishioner introduces these subjects, he discusses them through encouraging the counselee to discuss them, but he does not bring them into the conversation when there is no indication that the parishioner has thought of them recently himself and unless they are pertinent to the immediate conversation.

For too long we have felt that we are being religious only when we are using certain words or discussing certain subjects. I heard of a minister who considered announcing to his congregation that he wanted to talk only about religion when he called upon them. He was completely missing the point. Creative listening, as carried on by the pastor and others, is religion in action; it is overcoming barriers and releasing the resources of God for better and more abundant living as described in the Gospels.

Supportive listening is characterized by the pastor's being comparatively passive while the parishioner talks, unfolding his story, taking his time, making his transitions, getting off the subject, weeping, cursing, continuing. It does not mean that the listener goes to sleep, or sits like a hulk; it does not mean, as Seward Hiltner has said, "demonstrating our strength by outstaring the parishioner" by looking him steadily in the eye. It means being alert; it means nodding your head encouragingly; it means looking past the parishioner and out of the window or over his head at the wall; it means looking at the parishioner and looking away; it means waiting and hoping; it means relaxing within your physical body so as not to block the story through your own resistance and prejudice; it means trusting God and believing that good can come out of evil and hope out of suffering. Supportive listening is aided by the use of the eyes, the face, the alertness of the body even as it is relaxed, and above all by little grunts of *ah* and *um* and *um huh*.

Supportive listening is the kind of listening used in the formal confessional. The difference in our use of it and

the priest's in the confessional is that confession, as practiced in the liturgical churches, is strictly regulated by canon law and is formalized around the commandments. Thus the priest may not get at the underlying causes of behavior, but deals only with the overt act. If, as modern psychology teaches, all behavior is purposeful, then the overt act may be quite insignificant. For example, lying is defensive behavior from the psychologist's point of view. The fact that you have lied is one thing, but the reason for the lie is quite another. From the standpoint of theology a lie is a sin; from the standpoint of psychology it may be the key to an underlying problem that may become serious unless understood and dealt with. Many a mother, upon discovering that her son has lied to her, fears that he is headed for the state penitentiary. He *may* be headed for the penitentiary, or the psychopathic hospital, unless the causes of his lying, one link in a chain of behavior, can be examined. Supportive listening is the method that we use in relieving surface stress in order to get at the underlying causes of behavior, to bring them to the surface of the mind, and to immobilize their emotional force, so that they can be understood and dealt with by the counselee.

Interpretation.—A third phase of the listening method may be called interpretation. Some writers speak of interpretation as a separate method. This seems to me to be a mistake, for the simple reason that, without listening, there would be nothing to interpret.

Interpretation in pastoral work is a short-cut method; it is used primarily because the pastor is pushed for time and because the other phases of his *listening* method have broken down. Sometimes it is necessary to use interpretation because our people have no conception of how they may be helped through pastoral work. They come seeking advice, and advice they expect to receive, because they are accustomed to being told what to do, or because they want the responsibility of a decision to be carried by some one else. In some rare instances, advice is desirable for the reason that the responsibility of a decision is too great to be carried by the person who needs help.

Interpretation is characterized by the pastor's explaining underlying causes of behavior which the parishioner may not

be conscious of or understand. It carries certain risks that directive listening does not because the pastor stakes all upon being right in his interpretation, and he works upon the assumption that the parishioner will accept it. In this assumption he may be wrong, regardless of the truth of his interpretation. A fact may be a fact in reality and to the pastor's knowledge, but unless it is accepted as a fact by the parishioner, the pastor must recognize the limitation of its reality and work with the parishioner in his conception of it.

Reassurance.—The fourth phase of the *listening* method is reassurance. This part of the method is so different from the first two types of listening that it, also, is frequently described as an entirely separate method, and yet, like interpretation, apart from listening it has little legitimate use. Of the four phases of listening, it is the least effective, and yet of all methods it is used most by clergymen and physicians.

Reassurance is a positive statement by the pastor. It is an expressed opinion that a problem will work itself out or that the pastor believes that a parishioner will be able to overcome his suffering. It is encouragement. The limitation of reassurance lies not in its desirability, but in our failure to bring the encouragement desired when we reassure people. A person will not have courage because we tell him to, but he can be helped to develop courage through our listening to him, through our interest in him, and through our own courage. Then we can tell him that he has courage as *we observe that he has taken heart again.* That is reassurance.

As a method, reassurance should be used sparingly. It must be expressed simply if it is to be effective. The more words used while reassuring a person, the weaker becomes the statement. Small words are the strong words; in attempting to reassure a person, use simple terms and be certain that your voice and manner reveal that you mean them.

Psychologically, reassurance is for the Protestant what the statement of absolution is for the Catholic. "I absolve you in the name of the Father and the Son and the Holy Ghost," is the Catholic statement following confession. The statement of reassurance is, "I believe you will be all right"; "I can see a lot of hope in your case"; "I have faith this

will not throw you"; "There is no such thing as being ruined except as you think you are, and you don't think so in this case"; "I believe in you and I'm going to see you through." A soul-companion never condemns, never judges, but always attempts to aid.

You will note in the above statements of reassurance that the Catholic absolution is pronounced in the name of the Trinity, while the Protestant reassurance is pronounced in the name of the pastor and personalized around him. This is an advantage in that it is intimate and personal; it is a disadvantage in that it is human and is thought of as human by the parishioner. The Protestant's reassurance is limited in that it lacks the perspective, the far view, the support, of the Creator Himself.

In our book, *The Art of Ministering to the Sick,* Dr. Cabot wrote a chapter that is often accredited to me, entitled, *The Two Must Face a Third*—that is, the parishioner and the pastor must face God. I agree. I also recognize that, because of the lack of belief in God of many of our people, it is sometimes impossible to face the Third. Many of our clergy, in their attempt to be helpful, wander off into pious platitudes, only to have their reassurance fail. Two can face God when both know God; when one knows God, the other may gradually come to know Him, but it is a slow process and not brought about through an easy statement or an exhortation. It is brought about through the slow, persistent, affectionate demonstration of the nature of God.

If I were told that I could use but one method in pastoral work, I should choose the *listening* method.

EMOTIONAL ASPECTS OF SOCIAL ADJUSTMENT FOR THE CHILD *

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ADJUSTMENT and readjustment of the individual to himself and to his social setting constitute a major problem to-day. These difficulties range from mild states of anxiety to acute mental disturbances. Combined with delinquency and social dependency, mental disorders produce socially disturbing effects because of the large number of persons who require some type of care.[1]

Mental hospitals and penal institutions have traditionally been operated rather for the benefit of society than for those who need treatment. In so far as they have aimed to cure or to rehabilitate their charges, they have been primarily motivated by social objectives. It was expected at one time that delinquents, the group adjudged socially handicapped, could be frightened into acceptable social behavior. Although the approach has changed to one of education, the aim generally remains the same—namely, that of protecting society. With the mental hospitals, the case is not quite so well defined. For the most part, these institutions have been giving custodial care to those persons who are a menace to society instead of preventing mental breakdowns or helping the mentally ill to resolve conflicts in a satisfying social manner.[2]

Definition of Adjustment.—With the increasing complexity of life and of civilization, adjustments to everyday situations become more confusing and difficult. Adjustment implies fitting in, adapting to change, and relating oneself appro-

* Presented at the Georgia Teachers and Education Association, Columbus, Georgia, April 11, 1947.

[1] See *Psychiatry for Social Workers,* by Lawson G. Lowrey. New York: Columbia University Press, 1946. pp. 2–4.

[2] See *Psychiatric Clinics for Children,* by Helen Leland Witmer. New York: The Commonwealth Fund, 1941. pp. 356–58.

priately to others. Adjustment has personal and social aspects. The personal phase is based upon feelings and emotions that determine behavior, while social refers to the rules of society as well as to the ends in store for the individual.[1] Most of an individual's life consists of relations with and adjustments to others, and for the most part, these adjustments are social in nature. They are institutionalized and prescribed, and the values and sentiments attached to them are shared by the individuals who compose the cultural group. By means of these relations and adjustments, the biological urges and drives are directed to social ends. At the same time, the individual learns to become a socialized person capable of using organization, language, and knowledge to express himself and to make his adjustments. All social contacts, however, are interwoven with feelings and emotions.

Individuals in their social settings are classified into various groups such as parents, teachers, tradesmen, and ministers; and certain attitudes and ways of conducting oneself toward them are required and have to be acquired by each individual. This is a condition that to a greater or less degree the problem child cannot accept. He finds all relations difficult. His ability to conform to social rules and requirements is limited because of the adverse way in which the rules for adjusting socially have been presented to him by those responsible for his care.

Fortunately, educators are aware that many children require considerable help in accepting the rules of society and in becoming self-disciplined persons. Consequently, counselors, visiting teachers, and child-guidance clinical staff have been added to the school's program to assist in individualizing and in helping the maladjusted child bring about some compatibility of his social and personal needs as he comes in contact with others in his surroundings.

Basic Needs.—In considering the question of the child's needs, adults must be honest about their own personalities, biases, beliefs, emotional attitudes, religious loyalties, and socio-economic and political leanings. Unconscious feelings and values play a large part in the attitudes of adults toward

[1] Helen Leland Witmer, *op. cit.*, pp. 34–37.

the child and in their capacity to recognize the child's needs. Generally speaking, the child needs to be protected from distortions, from unnecessary deprivations and exploitations by adults, parents, teachers, and others engaged in work with the child.

The primary need of the child is to be accepted as a unique individual. Every child experiences some denial of his personal, temperamental individuality because even the most mature adult exercises parental preferences and a desire to see his child conform to the ideal that the parent has constructed for him. Moreover, every teacher has some partialities, often unconscious, which draw her toward one child and away from another. Furthermore, a child himself has some desire to gain parental approval and to be like the image the parent has created, however out of harmony with his own make-up. It is significant how the recognition of individual differences is resisted by professionally trained persons, such as teachers and social workers, who can see differences in mental capacities when disclosed by mental tests. But they reject individual differences in personality, temperament, and physical maturity.

The child needs warmth, nutrition, and bodily care so that he will grow and develop at his own rate. The emphasis should be placed upon growing, not upon fixed dimensions for chronological ages based upon the assumption that all children grow at the same rate. The child's physical needs for food, rest, sleep, and play relate very definitely to a feeling that he is well cared for and is obtaining the attention of those around him. Being well fed instills within him a sense of belonging and of well-being.

Psychological Components.—A child's capacity to feel secure with others and to make adjustments lies in the kind of relationship that exists between him and the members of his family. This aspect of adjusting to others characterizes two fundamental qualities—namely, self-security and the capacity to enter into and maintain personal and social relationships.[1] It is the individual who is comfortable within his family group who develops wholesome confidence in his own capacity to achieve and whose sense of personal worth

[1] See "Dependency and the Adolescent," by Mary E. Rall. *Journal of Social Case Work*, vol. 28, pp. 123–25, April, 1947.

is reinforced by the feeling that he belongs to his parents and can depend upon them. The self-secure, self-sufficient person does not exact more emotionally or materially from a situation or a relationship than it can give. Moreover, he does not become unduly disturbed when a situation or a relationship does not come up to expectation.

This is not to imply that the child experiences no disappointments, but rather that these feelings do not overwhelm him or prevent the forming of future constructive relationships. The manner and the extent to which the dependency needs of the child have been met by the parent-person are revealed to some extent in his capacity to establish relationships. The individual who is basically insecure as to his place in his family and with his parents, whose dependency needs are largely unmet in the family group, and who is in serious conflict in relation to them, can neither enter into nor experience in full the satisfaction of loving and being loved by others. The individual needs affection from parents if he is to develop an out-going, generous, and trusting attitude toward others. If he is denied libidinal satisfaction, he is likely to become distrustful, suspicious, and hostile.

Likewise, the child who has had sufficient satisfaction in an activity or support from parents and teachers to give up instinctual desires is able to go on to something new without a persistent feeling of deprivation or unsatisfied infantile longings. The widespread prevalence of enuresis is not unrelated to the fact that toilet training has been imposed before the child could accept a new habit. It is highly probable that the school people, like parents, are guilty of aggravating the child's insecurity in this area by their rigid overemphasis upon toilet training and by the fuss teachers make over "slips." The emotional tone or attitudes of parents and teachers toward personal habits is the important thing—not their actions. The child reacts to the tone and feels the tenseness or dislike in the adult's voice. In handling the situation, any anger or impatience creates more anxiety and feelings of fear for the child.

Since so many adults carry over from their own childhood a feeling of disgust and humiliation over matters regarding toilet training, it is clear that they are not able to treat the child under their care without emotional stress and nervous-

ness when dealing with individuals who have poor personal habits. Few children pass through toilet training without some degree of anxiety and conflict, and, combined with feeding and weaning processes, personal habit formation constitutes an important source of personality problems.

Moreover, the symptoms of sibling rivalry, often aggravated by overt favoritism for the new baby and the rejection of children by parents, are many and varied. Teachers have a great opportunity to meet the acute sensitivity of these children who feel that they are not wanted or not acceptable to their parents. In this group must be numbered the children of overprotective, solicitous mothers who hide rejection of their child under effusive care and relieve guilt feelings by "smothering" the child with attention.

Then, too, there is the facing of death or loss of a loved one, an inevitable aspect of life that mankind has to face. To-day, children are increasingly forced to face another kind of loss that is more perplexing and difficult than death—the separation or divorce of their parents, a situation that is so hard to explain to the child. In meeting this situation, adults must try to provide some kind of "cushioning" assistance because the experience is devastating to the young child and persistently disturbing throughout childhood and adolescence. The conflict of parents, the frequent accusations and hostile motives, all the bitterness and the competition for the child's favor act as psychological poison. Without a doubt, one of the child's greatest needs is to have a picture of adequate family relationships as a guide to his own future adult home.

The importance of problems relating to sex and the many taboos that surround this subject create need for understanding. The traditional ideas that children have no concern over sex differences and sex organs has been displaced by cumulative clinical evidence. It is confusing for children to comprehend the process of procreation, to accept maleness and femaleness, to see any sense in the explanations given and, at the same time, to strive to comprehend the violent reactions of adults to exposure, manipulation, or masturbation. Psychoanalysts state that the child passes through various stages of sex satisfaction—namely, oral, anal, pregenital, and genital—and that adolescents and adults are

adequate persons only if the psychosexuality of the individual develops normally.

The process of socialization within the home and the efforts of parents to train children as to their personal habits is frequently the basis for the development of abnormal sex curiosity and interests. Many investigators have shown that sex conflicts may arise mainly because of the attitudes of adults. It is usually assumed that most persons sublimate their sex interests and desires and thus avoid conflict. But clinical psychologists have shown that relatively few individuals satisfactorily sublimate sex desires.[1]

We cannot expect to dispose of the child's curiosity by purely biological explanations, for adults are not satisfied with biological answers. Adults need to clarify their thinking as to the use of sex in living, in feelings, in intimacy and affection. Parents, especially mothers, and teachers, especially women, are so often suffering from anxiety, disgust, or fear about their own sex functions and needs that they cannot tolerate the child's natural curiosities and activities nor can they give the child the understanding and help needed. It is not too much to say that the ability to establish meaningful relationships and to find satisfaction in family life through marriage is largely conditioned by childhood experiences and by the acceptance of masculinity or femininity and sex differences by the individual.

Socialization of the Child.—The child must learn to inhibit his responses to persons and things and to perform those acts that adults insist upon as the required actions in various situations. These actions include traditional manners, customs, and moral beliefs which parents respect and which they teach their children as the essentials of life. These lessons are difficult for the child because the required way of behaving demands the control of natural biological urges. Therefore, he must be repeatedly shown how to act and be compelled to comply.

In order to become socialized, the child has to learn to acknowledge and to accept authority and to recognize outside of himself some controller of conduct that may be unreasonable, but that is based upon established practice.

[1] See *Basic Problems of Behavior*, by Mandel Sherman. New York: Longmans, Green, and Company, 1941. pp. 297–306.

He must learn to carry out certain small courtesies and more important duties appropriate to his sex, status, class, and position. Moreover, he must learn to accept all the complicated and largely ritualized acts as sanctioned by the law and prescribed by the rules of social living.

Authority is merely a way of behaving toward individuals and situations. The development of a self-disciplined child calls for constant recognition and acceptance of the authority of the state and society which, to be really effective, must function not in police supervision, but within the adult himself. If the child experiences authority as coercive, severe, and brutal and as something that arouses fear, anxiety, and resentment, his socialization will be a compromise. Moreover, he will feel the tension, will resent authority, and will more likely develop persistent hostility against those who attempt to direct his conduct. As a result, the child may develop defensive ways of responding. This response will be seen in repeated refusal to follow directions, in resistance to suggestions, or in suspicious, paranoic reactions.[1]

Social workers in social agencies work daily with children who are not able to adjust or to adhere easily to rules and regulations. These children usually have been deprived, are very sensitive to their surroundings, and tend to compare themselves unfavorably with other children. The following case is typical of many children reacting to others in a most negative fashion.

> Tommy, a Negro boy, aged eight, had been placed in four foster homes. He complained constantly of how he was treated by other children and by his foster parents and of the attitude of his teachers toward him. He believed that all adults discriminated against him; that teachers failed to promote him because he did not come from a prominent family; and that every one "picked on him." He refused to coöperate in discussing his problems with the case-worker and insisted that some way be found by which he could live with his father, who had divorced his mother and remarried. His aggressive, suspicious behavior showed markedly when he was with children of his own age. Fighting and threatening them was his only means of gaining his associates' attention.

Whereas Tommy overtly rebelled against authority, which centered around accepting substitute parental care, older children and adults who have developed strong defense

[1] Mandel Sherman, *op. cit.*, pp. 159–98.

mechanisms tend to be argumentative—a kind of defense of the self by attacking others as a means of evading criticism of the self. The "attacking" type of behavior is a most common characteristic of persons who have strong feelings of inferiority. They are most likely to be aggressive toward and argumentative with persons who have greater prestige or are better informed. Fear and suspicion of their inadequacies make it impossible for these persons to relate in a socially acceptable manner to others.

Then, too, the child may conform outwardly to what is demanded or prohibited, but only because of fear and anxiety. The desired response never becomes an automatic response for the child; and he becomes preoccupied with the conflict between what he must and what he must not do and how he feels. He often releases his feelings in misbehavior that is symptomatic of his discomfort. It indicates that the imposed authority has no value and no meaning to the child, and his misconduct is a way of striking back at those persons in authority who made him fearful and unhappy.

But one of the most common ways of responding to difficulties and frustrations is through escape, which may be an attempt to evade responsibility. Such persons are usually unable to measure up or to carry out what is expected of them. They may deny their feelings of inadequacy by rationalizing that the goal or ends are not worth while. Frequently, the child who is unable to make adjustments socially may project his own feelings and claim that others dislike him. This was the situation in the case of a seven-year-old boy brought to the attention of the visiting teacher in a Negro public school of Atlanta.

> Jerry was progressing very poorly in the second grade and acted most of the time as if he was afraid of people. His mother's description of his fearfulness, his tendency to cry, and his reluctance to play with other children suggested difficulties connected with his trouble in school and his inability to read. It was found that Jerry was of normal intelligence, but his unhappiness was tied up with his fear of his mother and his teacher who would scold and punish him severely. He was most concerned over their dissatisfaction with him and shunned others because he expected to be treated in a similar manner.

Whereas the aggressive child at least makes a determined effort to effect an adjustment, the fearful, timid child like Jerry is not actively attempting an adjustment. The prob-

abilities of his final adjustment to social demands and to his personal problems may become less favorable than in the case of the aggressive child, who at least tries to manage and manipulate his surroundings. The withdrawn child is potentially more seriously in need of help than the aggressive individual who gains adult attention because he is so annoying.

Withdrawal, however, can be considered a kind of social adjustment because the shy, retiring person is unable to compete with others and retreats because he fears becoming involved in a situation that appears threatening. The withdrawal type of behavior is often encountered in the school child from five to seven years of age, who is forced to relate to new people and to new social situations that are wider than he has experienced in his family setting.

In order to bring about an acceptance of the new and the demands of society without aggravating the existing conflicts that children usually have when they come to school, teachers need to reconsider their handling of children and their problems and to think through what they do *to* children in their daily contacts with them. In some way, parents and teachers will have to devise ways to relate "the authoritative must" to the situation. This approach will help the child to see that the act is forbidden, disapproved of—not the child. When adults remove the personal element from authority, which does evoke resentment and hostility against both the act and the adult enforcing authority, not only will a more meaningful relationship between the child and the adult be possible, but the child will be more likely to accept the act as socially desirable.

To summarize, no one can prescribe a general method or procedure for helping children make socially accepted adjustments, because they are individuals with varying aptitudes, mental facilities, and potentialities. Undoubtedly, the largest single element in the situation is adequate provision of social, recreational, educational, and cultural opportunities, so as to facilitate the child's development. In addition, the adult-child relationship is of major importance because the child imitates, copies, and strives to emulate an admired, loved adult. Therefore, parents and teachers must take inventory

of themselves as potential models and be aware of what they really are as persons and of what they actually have to contribute to the development of the child. The adult must be consistent in his handling of the child, must be able to accept the child for what he is and be able to show sincere, sympathetic, personal interest in him and in his problems. School-teachers must realize that with their personal idiosyncrasies, emotional patterns, and fixed convictions influenced by formal training, they may create just as an undesirable environment for the child in school as he may encounter at home.

The family can and should provide the child with economic security, status in the community, and "belongingness" to a group, plus the much needed affection and love. But the school has a responsibility to recognize when the child is deprived of fundamental needs, physical and emotional. It is obligated to organize its procedures and to employ teachers who are emotionally mature, secure, and attuned to the gaps in the child's life as he pursues his educational plans. In reality, the socialization of the child depends upon how sane and coöperative adults are and how much the adults in the child's world care about what really happens to him as he strives actively to find his niche in society.

COLOR IS AN ADDITIONAL PROBLEM

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THE culture pattern, which shapes all of us until we gain enough understanding of it to emancipate ourselves somewhat from it, is a force to be reckoned with in the interview. We are so immersed in it that it is extremely difficult to pull out far enough to analyze it with genuine neutrality. In an interview between members of two races, a Negro worker and a white client or *vice versa,* these forces come into play in a special sort of way. Client and worker meet in the area of the client's expressed need, and this is the same as the area in which any client and worker meet. When they come from different racial backgrounds, however, there is apt to be an additional factor to be recognized as functioning in the interview. There is a questioning that goes on in the client's mind about what the worker thinks of his race and of him as a part of that race, and there is the same questioning in the worker's mind about what the client thinks of her race and of her. There is also the adjustment that each has made to his own racial identity as he handles himself in the interview with the other. Each has to test the other to see where he stands, and each has to pass the test of the other if the interview is to go forward successfully. If the worker has worked through to an emotional and intellectual freedom in the area of race, she can convey this to her client, even though he shows an initial distrust of her, for the force of her sincerity and skill is greater than that of the prevailing *mores.*

This can, perhaps, best be illustrated by an actual case. Some of the dynamics of what took place can perhaps be seen more clearly if the interview is quoted verbation. There are two strands in evidence—the major one of the case situation and the minor one involving the color line.

A soldier just returned from overseas comes in to the

agency to request a loan to return to his base,[1] and is interviewed by a white worker.

> "Private H. in office. He is a tall, well-built, dark-skinned man who seemed restive. I asked him what he had come to see us about and he said that he wanted to borrow some money to get to camp. His traveling orders show that he is due at Camp X to-day. He says that he has a good military record and wants to keep it that way. I noticed that the clerical assistant had put down Camp Y as his address, and I asked about this. He said that the clerk had been snippy with him and so he had not bothered to correct her when she put down the wrong address. He pulled out a piece of paper with his address and it happened to say Camp Y and he just let her take it that way."

The difference between his response to the worker and his response to the clerical assistant is interesting. Factually he knew that he had to correct his address, but he need not have done this with criticism of the clerk. He could have been neutral about the correction. Hostile feelings had been generated by the clerk, but his expression of this hostility was a separate force in the man, for all hostility is not necessarily expressed verbally. Why he felt free enough to express it to the worker, is not recorded, but something must have gone on between client and worker to permit him to say it.

The adjustment to racial difference between client and worker is at its maximum point at the beginning of the interview, and worker and client are both sensitive to it and working with it consciously. He may have felt enough security with the worker to be able to criticize the clerk to her. On the other hand, he may have been attempting to express hostility to the worker by his attack on the clerk, who was of the same race as the worker, but this took courage in him and it rested upon a permissive attitude in the worker. Because of the possibility of the presence of racial feelings in this attack, the worker would have to be all the more accepting of it, and of him, so as to dissolve it in her acceptance of it.

How the worker conveys her acceptance and understanding of the client, so that he can take hold of it and feel sure of it, is too infrequently caught in the dictation of the interview.

[1] The interview took place in the Home Service Department of the American Red Cross during the war years.

Her facial expression, the use she makes of her voice, and the feeling tones it carries, her posture, and behind these outward expressions, her deep inner conviction and sincerities—these are a part of her method of giving herself to the client. They are subtle and non-verbal, but they are real enough for the worker to be able to utilize them consciously and for the client to feel them and relate to them. If the worker has a genuine feeling of interest and sincerity behind her professional discipline, she will not err very far.

> "I asked Mr. H. what he needed the loan for and how much he needed. He said he needed a ticket to go to camp and meals on the way. I told him that we could call Travelers' Aid and have them get a ticket for him. I asked Private H. what had happened to his ticket and he said that he just didn't think he had one. He had just come from home, where he had been visiting his mother and father."

This is a rounding out of the factual material surrounding the man's request for a loan. It seems to contain little emotional material except for the client's comment about his ticket—"he just didn't think he had one." This should have aroused the worker, as the explanation is pretty lame and it needed follow up. Perhaps she was so eager to be accepting of him as a person that she missed the rather obvious inconsistency of his remark. If a worker is too eager to establish a relationship and misses the factual content of what the client says, she runs the danger of establishing the relationship on an unstable base.

> "I asked how it felt to be back in America again and he said it was all right. He hesitated a moment and then asked if there were anything I could do to help him with his allowance."

The reason for the worker's next move is not clear, as it does not relate to his last comment. Perhaps she felt that there was something troubling him and reached out in a general sort of way to see if she could find it. His hesitation in answering is an indication that there is more at work here than the simple request for a loan. She apparently gave him enough feeling of assurance to permit him to bring up a question about the allowance which was not a part of his original request. The availability of the worker's warmth and sincerity must have been strong enough for the client to have found it, and to have taken hold of it as he widened his area of discussion with her. Her question about how

it felt to be back in America again is a verbal expression of interest, but it is not in itself great enough to have convinced him of the sincerity of her interest. This can be conveyed from worker to client only if it is genuinely present in the worker, for she cannot give what she does not possess. If she has it in herself, it will permeate what she says and does and the client will find it.

> "I said I would be glad to if I could. He said that he had gone to visit his wife who lives in the South. He does not want to continue his allowance to her, as she has not been faithful to him. He said, with no need of prompting, that he had married her about two years ago and that she had put up $20 for the marriage. He had gone overseas almost immediately and his $50 allowance has been going to her since that time. He had gone to see her as soon as he landed in this country and had remained there about two weeks. He had had a pretty unhappy time. He hesitated and I asked if he would like to tell me about it."

The client elaborated, not on the technicalities of the allowance, but on the details of his marital life, and showed feeling about it. His hesitance may relate to the actual marital stress, or to his need to test the worker's capacity to accept him, or to both. He needed reassurance, which the worker gave by asking him if he wanted to talk about it, but her question left him free to refuse if he wanted to.

> "He said that she had refused to prepare meals for him and had at one time put him out of the house. I commented that that was not easy for him to take, apparently. He said that it was not."

The worker here gives him further evidence of her interest, and puts into words the feeling she felt he had. The worker needs to be careful not to give feeling tones to the client that he does not have, but that he may take on suggestibly because of hearing them verbalized, because of a dependence in him which the worker taps unconsciously, or because her prestige is too strong a force for the client to resist. When the worker verbalizes the client's feelings for him, she must be very sure of her diagnostic thinking and of the effect her words will have on him.

> "He had expected his wife to receive him with open arms, and that, at least during the time that he was there, she would do everything for him that he wanted done. After he left, she could again do as she pleased. He looked at me and asked, 'Do you want the truth?' "

The client is still testing the worker, wondering if she can take it, and he brings this out openly by putting it into

words. The client's testing probably has two roots, one stemming from his uncertainty of her acceptance of the material he needs to produce, the other from his uncertainty of her acceptance of him as a person, and this may have racial coloration. For her, they are much the same, and she meets them with an acceptance and a permissiveness that relax him and allow him further to unfold what is pressing underneath. Her acceptance of him as a person is in itself the reassurance he needs to bring out the underlying material, and her acceptance of what he says is acceptance of him as a person.

> "I said that I thought it might be better if we both understood what had happened. He said that his wife goes with other women. Occasionally she goes with other men, but for the most part she goes with women. She was cruel to him, going out at midnight and coming in at 4 and 5 in the morning and refusing to do anything for him. She and her mother were both discourteous to Private H., and both of them move in a circle that involves primarily women. When he left, he went up to see his mother and father in the North. When she heard what had happened to him in the South, his mother said that she hoped this would teach him a lesson."

The worker's comment that it might be better if they both understood had a dual effect. It is a fairly active way of helping the client to unburden, and it also reassures the client of the worker's interest and acceptance toward whatever he may want to bring out. The material this man brings out indicates his need for permissiveness in the worker. He seems eager to unburden and, therefore, the worker's activity becomes reassuring rather than intrusive as it might otherwise.

> "I wondered what Private H. thought he would do about the allowance. He was not sure and looked to me. I wondered whether he meant to continue the marriage. He hesitated and I waited, as I could not tell what he was thinking."

The worker's return to a discussion of the allowance brings the focus back to the man's practical request, which was the only part of the problem with which the agency could help in this single-interview situation. Her comment about the marriage was related to the allowance, as a soldier could not stop the allowance to his legal wife according to the Federal Act. The ships-that-pass-in-the-night quality of this interview establishes its own limitations, to which worker and

client remain sensitive throughout. The man is not quite through, as his uncertainty and hesitation indicate, and the worker, therefore, lets him continue with whatever he feels still needs to come out. She has defined the limits of this single interview by bringing the focus back to the allowance, and she then lets him go on to define its limits from his point of view.

> "Finally he turned to me and asked if I wanted him to tell me the truth. I said that I thought it would be well if we could get together on the story. He says that this is his second wife and that he is not divorced from his first wife. He has not told anybody about this and is afraid that if the army learns about it he will lose his good record. He married first some years ago in the South; he does not remember how long ago, but it was about the time he was in the C.C.C. camp down there.
>
> "His wife left him and married another man. He decided, when he was stationed in the South as a soldier, that if his first wife could remarry, he could, too, and that both of them would keep quiet about their previous marriage. His father had told him to divorce the second Mrs. H. and that would make everything all right. He is quite confused as to what to do and fearful about it. I commented that he would not be able to divorce his second wife, as she was not legally his wife. I said that the second marriage would have to be legally voided. He asked what that meant and I tried to explain it to him. I wondered if he had a lawyer who could help him with this. He said that he had been sent to a white lawyer in the South by the legal department at his field. He had gone to the lawyer, but because the waiting room was filled with white people, he had not remained.
>
> "We thought through together the possibilities of what he could do. He could write to the Office of Dependency Benefits and explain the situation to them, asking that the allowance be stopped; he could discuss it with his commanding officer; he could let me write to the field director at camp and let him handle it; or he could discuss it with an attorney in civilian life and have it handled in that way. He preferred to have a civilian attorney handle it for him. Together, we wrote a letter for him to sign to send to the lawyer in the South."

The client has now brought out the whole of his problem. The worker does not attempt to relate to the feeling tones in it, as they lie beyond the dimensions of a single-interview relationship. There is, however, a legal problem with which some help can be given and the worker accepts this as her assignment. She attempts to help him clarify by thinking through with him possible alternatives without throwing her weight with any of them. The legal tangle needed legal counsel, which the worker could not give and a reference elsewhere was indicated. Her acceptance of the situation for discussion had a therapeutic value for him, as it allowed him

to share his problem with some one; it gave him a chance to ventilate and thus to ease the pressure, and it helped him to clarify his thinking. Her interest was supportive, her permissiveness was relaxing, and their pointing up together possible moves for him to take helped him to become active about his situation. His comment about the white people in the waiting room indicates his feeling of security with her.

> "At the end of the interview Private H. said that he should have come to us earlier and smiled. I said that I was glad he had come. He said he had tried going to social workers in the South, but that they had been very sharp with him. He said that Negroes in the South cannot discuss their problems with white people, that they would not listen to them."

Here the client is trying to express his gratitude and the worker acknowledges it naturally. His next attempt is to separate the present worker from those whom he had known and to comment about the inability of his people to get help across the barrier of Southern prejudice. He says this now without evident hostility; it seems to be more of an observation than an expression of aggression.

> "Since we seemed to have finished most of the material about his family allowance, and since he had been in the office almost an hour, I brought the discussion back to the loan. He said that he guessed he needed only a couple of dollars for food; he had not eaten since yesterday morning and he was pretty hungry. He grinned at me and put his hand into his pocket and pulled out a railroad ticket to show me. It was a ticket all the way back to camp. I smiled and returned it to him, and said nothing. I asked if he had any overseas pay in the Army Finance Office and he said that he did not—he had drawn it all out to make the trip to his wife and then up to his parents and back to camp. I gave him a $2 grant and told him he could repay us if he wanted to.
>
> "When I gave him the letter to the lawyer, which was typed in the office, he read it carefully before signing it.
>
> "Brief Service: Closed."

The client's sudden burst of honesty is interesting. It is another expression of his gratitude and security in the relationship. The worker had earned this by her demonstrated capacity to understand, and his honesty earned for him the return of the ticket without comment. Her final move of giving him a grant when he had asked for a loan is somewhat an overstepping on her part. It was due to her subjective need to give, since giving was not called for by the

presenting situation. It probably did no harm, as he had been very much hurt and no one had given him much since his return from overseas, and it also had the positive value of demonstrating the worker's acceptance of him. Her comment about repayment may have made him feel that it was really a loan, so that it had a loan value for him. However, on the negative side, if he accepted it as a grant, he may have felt that it was a paternalistic move on the worker's part.

In looking at the interview as a whole, two strands can be seen: First, the evolution of the request from loan to allowance to marital difficulty, which might have been present in any case, regardless of race, color, or creed; and second, the racial adjustment of client and worker to each other, in which the client had to test the worker's sincerity and capacity to understand and she had to pass that test. All clients test their worker, but there is an extra barrier to be overcome when client and worker are of different cultural groups.

Private H. came in with a good deal of aggression, stemming from his marital life, the careless comments of the clerk in the outer office, and from the friction resulting from the *mores* of the society in which he lived. The worker met these in meeting him, and she was sensitive to them as well as to him as a person. Once he felt secure with her, he could begin to focus on the more individual problem of his own life. This problem would probably not have come through had the worker not been able to recognize the racial insecurities and hostilities first and to remove them from the path of the interview.

The cancellation of possible racial forces in the interview is a relatively small task for client and worker, but it is an essential one, without which the interview cannot proceed to other material. The skill and sincerity of the worker remains a primary factor in the unfolding of the interview, but unless the worker has cut through personally the binding power of the American dilemma, she will not be free enough to be available professionally to her client of a minority group. This relatively small part of the interview grows out of a large piece of work by the worker on herself, and until it has been done the client will sense the worker's real

feeling, even though it is veiled, and he will not be able to open up as he needs to.

During the last few years there has been an increasing literature on the psychological and cultural meaning of race and this is a hopeful sign. Sociologically, we are beginning to ventilate our ideas and feelings and, as in case-work practice, clarification and a will to be active about it will follow. Meanwhile color is an additional problem to be resolved within the case-work relationship before client and worker can be free to relate to the individual human problems that lie beyond.

A MENTAL-HYGIENE APPROACH TO THE INTEGRATION OF A MULTI-FUNCTION SOCIAL-SERVICE AGENCY

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OUR contemporary social-service picture seems to present two major deficiencies—an inadequacy of agency resources to meet the many needs and a serious lack of skilled personnel. To mention but a handful of these deficiencies in service, there are the increased demands for the services of psychiatry, family case-work, child guidance, vocational guidance, employment counseling, and health care. To-day, especially, one cannot but view with alarm the growing tendency to constrict programs of social service, whether federal, state, municipal, or private.

What has been the effect of this expanding need in the familiar areas of our local communities? Social agencies of all kinds have been struggling to meet the increased need for services. In some instances agencies outbid one another for personnel. The number of agencies with month-long appointment lists grows. Some, we hear, have suspended intake indefinitely. Some restrict intake to the harsh emergency only.

This means that fewer citizens are getting help, and many become weary of the run-around they experience in trying to obtain it. We dare not think of the needs that are not expressed, but our professional conscience tells us that they are numerous. A problem that does not receive proper attention at an early stage of development will finally expand into a full-blown dilemma which then will require long-term, highly skilled, and costly care.

For example, there is the young student who sought training in air conditioning, one of our glamour occupations. He was improperly advised of future job possibilities at the time, and became increasingly frustrated when he could not find work in his chosen field. He then began searching for another

and a better choice until he was exhausted, at which point he needed help not only with his educational and vocational problems, but with his emotional conflicts as well.

To what does this lead us, and wherein is our challenge? Perhaps a reëvaluation of the broad meaning of mental hygiene in its bearing upon the total personality and all of its interdependent relationships will open a gradually widening approach to a more effective handling of some of to-day's tasks. We have many different categories of professional social service, but we lack the specialists to carry them on. We are interested in prevention, but find little time to plan for it when all of our effort is centered on the acute problem. As individual specialists, we continue to develop the high science of our skills. We go on working with the so-called standard case loads because somehow that is what we always did. The closed shop of our professional disciplines has done much to develop our knowledge and skills to levels at which we can justly be proud of our achievements. We have not always been equally enthusiastic about unifying our strengths, pooling our knowledge, and integrating our services and skills. Except for a few notable efforts, cross fertilization among the social services has been generally held to be a matter of liaison, of good public and community relations, rather than of integration of total services to meet total needs. Herein, it seems, lies a possible application of the practical meaning of the concept of mental hygiene.

This application of team work is not new. In military service it was given new expression in the form of the so-called clinical teams. Unfortunately, this concept has not completely penetrated all of our community services, to effect a mutual mobilization of strength. Agencies are not sufficiently open or psychologically accessible to individuals in the community, to a degree that makes them and their services known to large numbers of people. In this there is something slightly askew. Whenever we are faced with economies or rising needs, or both, we are prone to deplore the threatened dilution of our skills, but the answer is not only to demand more skilled personnel and more skilled agencies, but to search and use all that we have on hand to the very maximum—yes, even at the risk of trying something different. Many of us believe that real economies can be effected by eliminating

duplication, combining resources, and building adequate community-wide screening, information, and reference services. We must also evaluate every professional job on every level in order to utilize individual and mutually supporting skills to the maximum degree.

Our primary interest must always be service to the individual. To his needs we must bring our skills as well as our understanding of all existing resources that might be utilized in rendering effective help. Part of this job involves education and training—a spreading out to all who work with people, regardless of their level of skill or professional training; a high degree of sensitivity to the manifold facets of an individual's problem. Although we may work within the structure of our specialties—family case-work, psychiatric social work, medicine, psychiatry, and so on—the real concern of mental hygiene is the flexible integration of all of these elements. It is within this constellation of all services and skills that the sum total of the community's and the nation's social-service forces can be mobilized. This is one way of meeting the real challenge such a mental-hygiene orientation demands.

At a Veterans Service Center we have endeavored to apply this mental-hygiene concept of meeting total needs of the individual through an integration of all of our resources with the total personality need of the veteran. I shall discuss here a few of the more important aspects of this agency's development—its problems of integration among the different units, use of staff, in-service training, the creation of a chain of supervisory links, and use of group procedures in meeting staff deficiencies and high loads. The center has been engaged in what might be called an experiment through being a first-line agency of prevention and service, meeting many problems on the spot and directing to appropriate agencies those that require continuing care. This agency has taken a first step toward helping over three-quarters of a million veterans in its three years of existence—a fair sampling of any segment of the population.

The center was organized in early 1944, in recognition of the fact that many discharged service men would be facing problems of adjustment on their return to civilian life. In mapping out the areas of greatest possible need, it appeared

that they included chiefly questions and problems relating to medical care and to psychiatric care, and family, educational, and employment problems. No agencies or special-interest groups have participated except those whose services are dedicated to the needs of the applicant, without possible secondary gains for the agency involved.

To-day, the Veterans Service Center consists of twenty federal, state, municipal, and private agencies. They are housed under one roof in a nine-story building. The Veterans Service Center is, in a sense, the holding company for these agencies. The two groups of personnel represented are the staff of the Veterans Service Center and the staff of the various so-called loaned agencies. To the center's staff belong, on the administrative level, the director, an assistant director, and a chief of community relations, of public relations, of information service, and of research and statistics. Under administrative service are the files and the mimeograph, mail, and business-management units.

In addition, there are three case-work supervisors: one who is responsible for intake, with a staff of twenty-two receptionists; one who, as the chief medical social worker, is responsible for the health unit, with a staff of five doctors and five social workers; and one who is responsible for the case-work unit of six trained and experienced case-workers. There is also a chief of the business-counseling unit, which, with four consultants and the last mentioned units, make up the center's own four key operating units.

On the loaned-agency side, there is a total of about one hundred and seventy-five counselors, including the chief of each unit. The total direct service staff, center and loaned, is under the supervision of the assistant director, who is responsible for all internal operations and service. Altogether there are about three hundred counselors, ranging from psychiatrists, physicians, psychiatric social workers, junior case-workers, to the large group of untrained counselors. The units, which are composed of Veterans Service Center staff, are directly related to the agency's administrative and supervisory structure, as in any traditional agency. The loaned agencies are responsible to the center indirectly and by agreement as to their function and integration with the center.

From its inception, the center's chief goal has been to pro-

vide as many of the most needed services as could be brought together in one place. Beyond this, the center's job was to make certain that all veterans who could not be served directly in one interview at the center would be referred to community agencies prepared to give a continuing service. In this sense, the agency could be considered a community-wide information and reference point for all agencies and service groups. This meant, too, that there was no duplication of agency effort. Although, in some instances, the service given at the center has overlapped the work of the parent organizations, in no sense has this ever involved a question of competition between the center and the community agencies. If anything, the fact that an agency in the community had a branch unit at the center meant that they supplemented each other's effort to the advantage of the veteran. In all instances the loaned agencies took on new responsibilities in being at the center. This relates to one of the key points in the process of integration.

Very early it appeared that, although the idea of such a multi-function agency as an on-the-spot and reference service had much potential merit, it was quite possible that the veteran would be given the same run-around among the services in our building as we were trying to prevent him from experiencing in the community. We also knew that we, as the central agency, would have to assure maximum service both quantitatively and qualitatively on the part of all agencies included at the center. This in itself held numerous pitfalls and dangers in the attempt at a true integration. The change in orientation to practices with which loaned agencies were faced was that their counselors achieve an acceptable quality for the service given by their agency, that they keep uniform center records, that working hours conform with those of the entire center, and that procedures for the flow and control of appointments be observed. Also, all agencies were to work with the center's supervisory staff. Here it was expected that they would participate actively in a mutual integration of their own service with all other services in the building.

It was on these points that all loaned agencies agreed to participate. The motivations for such an extension of service on the part of loaned agencies were numerous. The vogue of service to veterans was one factor; the recognition received,

another. However, the gap between agreement in policy and actual practice was often considerable. Working with as heterogeneous a group of services, people, and skills as could be brought together anywhere, it became necessary to set up areas of responsibility for the center's staff that would help mold this group into one agency that could be called a service center. There were problems of overlapping interests among many units; almost all counselors, interestingly enough, had a tendency to want to solve "all problems for all men." It seemed advisable that the concept of specialization be accepted by all agencies and that each unit have as its goal service to the fullest extent within the function and skills its particular unit had to offer. At the same time, it would be necessary for all counselors to be aware of the relationships between one need and another.

On the operational level, the very first application of our principle was carried out by the reception staff. This staff, under the supervision of the chief of intake, engages in the following operational responsibilities: they participate in a program of in-service training, work at a battery of information telephones, man the central executone control system, coördinate the flow of applicants and appointments for units, regulate the flow of applicants throughout the building, and control the flow of records from central files to the individual units and counselors. The basic job of the receptionist is to give information and to screen and route applicants to the various units throughout the building, as well as to obtain initial face-sheet information on applicants who are sent to units for interviews. Receptionists rotate on a bi-weekly basis between the various floors and the main floor in order that each receptionist may be fully informed as to the total operation and nature of each service. These receptionists, although not professionally trained, are carefully selected, many having had previous interviewing experience in counseling units of the military services. They are all adaptable to an in-training program which develops interviewing skills of a very high level.

Receptionists are trained to view each request in relation to the individual's total needs. They are helped to develop a sensitivity toward what the applicant does not say about himself and his problem. They have been taught an appre-

ciation of the cause-and-effect relationship between problems. A decision made by the receptionist may well mean the difference between helping an applicant get on the road toward the service that will meet his needs, and involving him in greater difficulties in the future, through a faulty diagnosis of his problem.

This orientation, which takes into account the many possible variations in which problems may be presented, prevents the kind of quick and offhand decision about a person's needs that frequently has the result of closing avenues of service, especially in an early stage of the development of a problem. Decisions on proper routing to the specialized units for service are not necessarily made on the basis of the applicant's request as literally stated. "I want a lawyer," may mean that the applicant is involved in an altercation with his business partner. This applicant might be first referred to the business consultant, if the problem appeared to be primarily one of helping him with a phase of his business. If, on the other hand, the situation has already defined itself to the point where legal procedure is indicated, he is sent to the legal consultant. In either case he can be re-routed from one consultant to the other later.

"I want to talk to a lawyer" may also involve a domestic situation. It may mean that the applicant is separated and wants to know about his legal rights. He may be contemplating separation, divorce, or custody of children. Again, depending upon the phase to which his problem has developed, the receptionist could refer him to a legal consultant or to the case-worker for discussion of a family problem.

Recognition of the interrelatedness of problems, which at any particular level may best be dealt with by one service or another, makes for flexibility in our handling of applicants. It assures them a start with the service they most need at the time of their request. Again, although they may begin with one unit, they may end up with a different service from the one their initial request implied. This gives the applicant the greatest possible choice of help and assures him of getting to the core of what he needs with the least possible dispersion of effort.

The sensitivity required for this job is considerable. Knowledge of the various unit services and their interrela-

tionships must be thorough in order to assure an effective intake job. It might be asked why it is not necessary for the receptionist to be a trained worker if he is called upon to take this degree of qualitative responsibility. We could never have justified the hiring of twenty-two trained workers. We have found that intensive, specialized training here under a trained case-work supervisor has enabled these receptionists to meet the demands of their job.

The following example will demonstrate how the various units in the building link their services together for the benefit of the applicant:

A veteran who came in to file for educational benefits with the Veterans Administration Contact Unit was seen to be quite unrealistic. He had previously made several unsuccessful attempts at widely different educational plans. The consultant could, by law and under the function of his agency, fill out the proper forms, initiating the veteran's entitlement to his rightful benefits. With the orientation and training the counselor had received at the center, he thought that under the circumstances he would only create another problem for the veteran if he carried out literally the man's request for service. The counselor noted much pressure and anxiety, and the veteran was referred to one of our case-workers with whom he was able to work out his need of and interest in psychiatric treatment. After screening by our case-worker, he was then sent on to our panel of volunteer psychiatrists. This panel will take for treatment neuropsychiatric conditions that are non-service-connected in origin. This was worked out directly between our case-worker and the panel's intake worker.

Each worker who had contact with this applicant passed on his briefly recorded impression to the others. The proximity of services, their free exchange, and the use of one another's facilities and information, as well as the experience gained in working together, help tremendously in determining the nature of the service to be given and the disposition to be made of the case.

This handling of a situation involved an intensive period of training, both individually and in groups, of all the counselors concerned. Under other circumstances the handling

of a problem might move from the intake worker of the psychoanalytic unit to one or more other agencies.

The manner in which integration is achieved begins early with new units and their counselors through a general orientation to the structure and philosophy of the Veterans Service Center. This is followed up by staff meetings, use of recorded material, and discussion of the problems encountered in the working relationships between units. It has been in these areas that the center's case-work staff has been used actively and continuously because of their psychiatric orientation, experience, and additional in-service training. As members of the staff of the center, these workers have been in a position to bring to almost every operational phase of the agency the orientation and philosophy that we have been discussing. The most skilled case-workers and the case-work supervisors have been given for supervision those units in which the need is greatest. Others in turn have devoted their time to the supervision of other units.

The chief of each loaned-agency unit again has had ultimate responsibility for the continued training of his counselors. This process has been at times somewhat difficult. While as a rule training began with a good deal of overt coöperation, time and closer working relationships often brought out the latent differences inevitable in such a working relationship. The fact that all counselors from loaned agencies, including their unit heads, had become well set in their patterns of work, and certainly owed their primary allegiance and jobs to their parent organization and not to the center, produced such familiar statements as: "This is the way I have always done it," or, "This is in keeping with what my agency wants me to do," or, "It is against our rules to do it this way," or, "We don't keep records for our agency. Why should we for you?" or, "Why should I have referred this person to X unit within this building, since, if he needs their help, he can look it up in the directory or talk to the receptionist on the main floor?" In all but a few instances, these problems of integration could be overcome only through a gradual process of teaching the basic skills of interviewing, and of helping counselors to acquire greater sensitivities and to become truly responsible for the nature of the service this and their own agency represented.

Where, after a period of time, the resistances became such that the negative manner in which a unit gave service became a real concern, not only to the center, but to other units whose work was being affected, conferences with parent-agency heads were necessary. The first step in such conferences was agreement on the basic issues, letting the parent agency itself take whatever responsibility it could toward improving the orientation of its counselors. If this failed, the parent organization might be given the opportunity to change its personnel. The head of the unit involved is always the key person in this kind of situation, and a good deal depended upon his participation.

Beyond this, the center could not permit an agency to remain where a mutually acceptable set of standards could not be agreed upon. In only two instances was it necessary to request withdrawal of the services of an entire unit. In another, a portion of the staff, including the unit's head, was changed. In others, individual transfers of counselors were effected. An important element motivating the degree of coöperation with other agencies here is their open commitment to the purpose of the service which they had originally agreed to join. To break off such a relationship because of unwillingness to meet the standards of the joint effort, as agreed upon in principle at the beginning, creates more problems than a sincere working through of the difficulty.

In such negotiations, which in one form or another are a continuing aspect of intra- and inter-agency liaison, it has been necessary for the center to guard against setting rigid standards as well as to consider the variations among individuals and units, their skills, and their functions. Although in-service training should be a forward-moving process, the rate of acceptance, the refinement of interviewing techniques, and so on, must take into account the normal factors in any learning process.

As might have been expected, most of the personnel of our loaned units slowly formed a new identification which frequently was used positively with the parent agency. If anything, this at times created problems for some of the units. Because of their greater flexibility and the increased sensitivity with which they gave service, their practices occasionally became subject to questioning on the part of their

parent organizations. At this stage, the center had to take responsibility for what had occurred and the evidence of satisfactory service given usually led the parent agency to accept the change.

This situation was most often encountered where problems of staff ratio to case load came up. For example, a Veterans Administration contact representative in almost all regional offices is expected to see about thirty applicants a day. The job at the center, however, is different in that all applicants referred to our contact representatives are screened at reception, so as to require a full service in every case. This means a more qualitative job. A simple point of information can be answered by our receptionist without referring to the Veterans Administration unit. At the regional contact offices, on the other hand, where seeing the contact representative is the applicant's first meeting with the agency, a simple one- or two-minute question might be tallied in the total of contacts made in the course of a day. For this reason the ratio of staff to applicants at the center has called for a greater number of counselors. This does create a problem of variation from the policies of the parent agency. But when the real question—namely, that of adequate service to meet the need of applicants—is made the issue and is again demonstrated through case material, the parent organization's policy can be made more flexible.

The process of integration over a period of time has shown that some units developed more quickly to a higher level of effective performance than others. Since at no time would it have been reasonable for the center to expect agencies to staff their units to meet peak loads, the handling of volume and its control to the units has been a continuous problem. At the height of our load, the center was handling 12,000 applicants per week. A normal average has been about 6,000 per week. Scheduling advance appointments early and late in the day has been one method of equalizing the distribution of load to our units; spreading the lunch periods of the staff from 11 to 2, another means. But, nevertheless, units have often been faced with loads that they could not absorb.

One of the means through which this problem was met was the introduction of a group process in our higher-volume

units. Our group efforts are based on the fact that in some of our units there is much material of an informational and interpretative nature that concerns every applicant who comes to that unit. Presentation of such material to a group, along with a statement of the purpose of this general orientation and discussion, assists each applicant in focusing his special areas of interest and the problems for which he wants help.

In an educational unit, for example, groups of five, ten, or fifteen applicants are scheduled to be seen at varying times during the day, depending upon the rate of intake. They are given all the information about G.I. educational benefits; the financial, housing, and family problems that may arise; the status of the schools, their courses and general requirements, and their policies in the matter of credit for past educational and military service. A brief discussion of general questions follows, and each member of the group is helped to relate this to his own particular situation, being told that, so far as is possible, he might try to formulate his own needs by the end of the group session.

At the end of the session, they are given the choice of several decisions: one, they may feel that this session has answered all of their needs; two, they may wish to discuss their problem with an individual counselor; three, with or without individual counseling, they may want other services at the center about which they have been informed while in the group. The group leader then immediately schedules individual counseling interviews for those who are interested and makes appointments, where indicated, for other units in the building.

Through this method of coördinated group and individual counseling, we have increased the load capacity of a unit of seven counselors by about 25 per cent. When the applicant gets to the individual counselor, he is usually able to arrive at his problem more quickly, has less need for general information, and engages in a more purposeful and productive solution from the start. A reduction in interviewing time has been achieved, yet the over-all service given is equally, if not more, effective. Those to whom the group session alone has given a satisfactory answer do not need to see the individual consultant.

With a change in content, the basic principles of this group process have been worked out with widely different services at the center, and, in each case, have proved a real advantage both to the applicant and to the agency, enabling the latter to render service to more persons at the specific time when it was needed. In these units the use of future appointment schedules was usually not necessary. In some units this method is not feasible in this setting. (In the traditional case-work agency, there are several applications of this process, some of which have proven quite successful.)

The use of groups has been particularly interesting in the handling of requests for vocational guidance. Vocational-guidance agencies in this city have for some time been so overburdened that applicants have had to wait several months before being seen. We recognize that people usually apply for help when they are ready for it; having to wait often loses for them the service they want. Applicants who requested this service at a time when it was not available to them frequently decided for themselves to go ahead with an educational or job plan, retaining their doubts and questions as to the choice made.

Several of the units at the center faced this inability to get individuals to adequate vocational-guidance facilities promptly and many of these people found their way to the case-worker. Our experience in meeting such requests showed that most applicants had only a vague notion of what they wanted. The idea of vocational guidance as a panacea for all problems and a magic key to the future has been what many veterans brought with them from their military experience. We suspect that this is a prevalent notion on the part of the general public also. Vocational guidance has become a basket into which people feel that they can dump their conflicts and anxieties, trusting that somehow a solution of their problems will come out of it. This observation concerned us very much. Also, since from twenty-five to fifty such requests appeared at reception daily, it was decided to centralize their handling.

Our old method had been to give the reception unit the responsibility for screening requests for vocational guidance and testing and for referring them to other units as follows: (1) requests relating to job interest and problems to the

employment-counseling unit; (2) requests relating to problems of interest in education to the educational unit; (3) requests in which the problem was one of obvious confusion to the case-work unit. On this basis these units were all dealing with the same as well as different aspects of the problem. Dispositions were always appropriate to the main problem found, and varied from reference for psychiatric care, to job, educational counseling, or direct reference to a vocational-guidance agency. Many of these applicants had, at one time or another in the past, been served by a vocational-guidance agency and were now requesting the same service again. (This presents a potential area of discussion which is outside the scope of this paper, but which should be very fruitful.)

The change that we made in our procedure was as follows: The counselors in our employment and educational units had had experience and training in vocational-guidance procedures. Since the heads of these two units were the most skilled personnel in this field in our agency, a plan for vocational screening was evolved with them. Applying the principles previously mentioned in discussing the educational unit, we formulated the following content for the group: Since the majority of veterans have but a very slight and often an erroneous idea of the service they are requesting, the session opens with a brief description of its purpose, the help offered by, and the limitations to be expected of, educational-guidance procedures. Applicants are told that in the course of this session they may be able to clarify some of their questions; that there will be discussion; and that at the end of the discussion they can make a choice among the following services: (1) an appointment with a case-worker; (2) an appointment with an educational consultant; (3) an appointment with an employment consultant; (4) a direct reference to a vocational-guidance agency; or they may decide that this session has answered their needs and that they are not interested in anything further. They are reminded of these choices at various appropriate points throughout the session.

The group counselor indicates that an interest in vocational guidance may arise from an indecision over a job versus further education, because of curiosity as to how one would

"make out" in a job or perhaps because one may have been deeply troubled for a long time as to how one can fit into the world in a useful way, both to one's own satisfaction and to the satisfaction of others.

This preliminary orientation, which consumes from ten to fifteen minutes, leads to the suggestion that each individual raise questions which, beyond what had already been said, will help him to make his choice of service at the end of the session. In every group, at this point, its members have become very active, so much so that at times it has been found best to rotate the opportunity for comment around the table. Usually, before the leader has become involved with one person about his problem, others express their views as confirming or being different from those raised by some one else. This interaction has always been spontaneous, and, because of its highly charged content, has been a manifestation of the pressure and confusion under which these applicants have been laboring. About ten or fifteen minutes of this discussion, in which the leader has merely summarized content from time to time and made an effort to limit the scope of the discussion, has been unusually helpful from a diagnostic standpoint.

Various degrees of disturbance have been found—from what appeared and were later confirmed to be full-blown psychotic reactions to confusion that was amenable to a relatively simple counseling service. There have also been individuals who had been through the traditional vocational-guidance procedure. The repetition of their request for such guidance usually indicated a need for case-work or psychiatric help.

An interesting observation here has been the freedom with which applicants openly chose to "see a case-worker for a personal problem" at the end of each session. About 20 per cent of the individuals thus handled have requested this service. The division among other services has been about the same.

A further validation of this procedure is the degree of movement that can take place in the individual members of a group of strangers and the fact that a large percentage get beyond the literal implications of their original request as stated at the reception desk. A follow-up procedure was devised, giving each member of the group a form to return

to the center on which they could state where this help had led them. Thus far, 98 per cent have expressed a feeling that they gained a good deal out of these sessions. Many have felt that they have resolved their confusion and are now clear about the direction in which they are planning their future as to job or education. Where the replies have been negative, the applicant is sent a note asking if he would like to return. In these cases an appointment is usually made by the previous group leader with the case-work unit.

Another phase of inter-agency integration has been our concern over the maximum utilization of each unit's service in contributing to the efforts of other agencies. An example of this between two of our units will illustrate. For some time our case-work staff, in its liaison work with the Veterans Administration, worked in a rather cumbersome way when attempting to clarify the status of veterans with the administration. We were often confronted with the problem of trying to fit the veteran back into the services of the administration, or to determine whether there might be a basis for renewing a previously rejected application for treatment, since additional evidence pointed to the possibility that the veteran's condition was service connected.

It was particularly in the area of neuropsychiatric problems that both the worker and the veteran lost much time in determining whether he should return to the Veterans Administration or whether the worker should begin planning to refer him to a community clinic. Since the addition of an annex of the local Veterans Administration mental-hygiene unit to the center, our workers have had direct access to administration psychiatrists and social workers. This has proved a very simple and effective way for the administration to take responsibility in situations in which it is warranted, and to begin, through their own personnel, to fit the veteran into the framework of the administration. This has been time-saving for both agencies and a very real help to the veteran. The Veteran Administration's mental-hygiene personnel responsible for the continuing treatment of their patients can, at any appropriate phase of the treatment, use the various agencies in the building. In referring a patient to the employment or to the educational unit or to some other service.

the advantages of ready communication between staffs are obvious.

On the subject of maximum utilization of personnel to meet staff deficits in relation to a high intake rate, our health unit might be used as one example of how this problem was met. This unit, under a chief medical social worker, consists of one medical director, five part-time physicians from the New York City Department of Health, and four well-trained case-workers. Two "junior case-workers" (workers with some experience, but little formal training) are also utilized. In addition, there are two nurses, a receptionist, and a clerical staff.

The function of this unit is (1) to provide medical examinations of a simple pre-diagnostic nature, so that the case-work staff may make appropriate reference of cases to community clinics; (2) to give premarital, civil-service-employment, and other routine examinations. The doctor alone is usually concerned with this aspect of the job. None except emergency treatment is given.

Our problem had become partly one of proper routing of applicants into the health unit. Our experience has shown that the volume and type of health complaints with which we are dealing divide themselves into the following categories: about 30 per cent are simple routine examinations resulting in a prescription and a suggestion that the applicant see his family doctor or attend a public-health clinic; about 30 per cent require reference to a hospital or to a Veterans Administration clinic for readily diagnosed conditions of recent origin (for reference to the Veterans Administration, these conditions must have their basis in a previous service-connected illness); about 40 per cent consist of chronic organic or emotional conditions. A detailed list of the types of problem, the interviewer, or the doctor to whom they should be sent (always with a provision for possible re-routing) is used as a guide by a specially trained receptionist.

As men come to the health unit from the main-floor reception unit, the receptionist in the health unit takes a statement of the problem and fills out the face-sheet information for the record. Depending then on the nature of the problem, the veteran may be seen first by the doctor, by a trained

worker, or by a junior consultant. Each of these may complete the case without further consultation with the others. Over a period of time, working relationships have been achieved, so that the use of one another has become routine whenever indicated. All referring of cases to and all consultation with other agencies and clinics and their social-service departments are carried out by our case-work and junior case-work staff.

This type of handling requires long experience in community and inter-agency liaison, knowledge of the practices and requirements of other agencies, of fees, of Veterans Administration service-connected versus non-service-connected policies, and so on. The doctor's recommendations to the case-worker, unless he completes the case, are in terms of problem and type of medical need indicated. The worker matches the resources with which he is familiar with the patient's need. The handling of referred cases has been 95 per cent effective, meaning that applicants received the help they needed. Where an applicant does not receive the help needed, he is called in for rediscussion or is re-routed to another clinic.

This over-all procedure in the health unit has made it possible for all staff members to function within the areas of their greatest competence. The doctor limits himself to the medical phase, either dealing directly with the patient or in consultation with the case-worker. The trained case-worker deals with all difficult chronic cases, a high percentage of which turn out to be neuropsychiatric problems, and works out appropriate resources for treatment. The junior case-worker handles a greater volume, about three to one, involving uncomplicated references to clinics.

This arrangement of volume to needs and to the skills available permits the highest possible volume of cases while continuing to assure service of adequate quality. While we previously had the same set of skills in the health unit, there was considerable conflict among the staff as to its professional prerogatives. By approaching this from the standpoint of the most effective use of the skills available in relation to the kinds of demand for the service made upon this unit, we formulated the above framework.

Reference has been made several times to a follow-up procedure as a means of evaluating the effectiveness of our services. Each counselor in every unit has been required to give follow-up forms to any veteran who is referred to an outside agency or resource. This has given us a constant check on the operation of our units, as well as the degree to which community agencies have been able to meet the problems of veterans referred to them.

When this procedure was first established, it met with considerable resistance on the part of almost every unit except our case-work and health units. Only when each unit began to see the use to which they could put both positive and negative returns did this material get woven into the center's and the unit head's supervisory job. The fear that the center was "checking" on the effectiveness of individual counselors was not without foundation. But as each counselor became more responsible for the service he gave, this feeling decreased because, along with his greater responsibility, he was also taking on a sense of obligation to examine what he was doing.

For the center's community-relations unit, the information about the services the community agencies were giving set the basis for many mutually helpful discussions. Community agencies have at no time expressed any objection to this procedure. Some have been frankly appreciative of the opportunity it has given them in providing another supervisory means for insuring their own good service. These forms have been returned by veterans at the rate of about 35 per cent of the total number given out. Over a period of time nearly 97 per cent of all returns have been positive in the sense that the applicant obtained the service for which he was referred.

These are a few of the problems with which one large multifunction agency has been concerned and the solutions that were reached. As stated at the beginning, it has been our goal to make the widest possible range of services available to meet literally almost every social-service need of our applicants. In taking on this responsibility, we have attempted to view all needs in relation to the total personality make-up of the individual, seeking wherever possible to offer help for

the immediate as well as the secondary and long-range problems of the individual. The philosophy of our staff training and our integration of agency functions has been to achieve sensitivity to the duality of cause and effect inherent in all problems. The components of emotional stress as they play a part in almost any area of adjustment, no matter how simple the symptomatic picture may seem, has been a primary consideration in our application of a mental-hygiene concept.

In the operational phase, a threefold constellation of factors has been our guide: the needs of people, agencies and their function, and the skills of personnel. Through our constant search for the interrelatedness of people's problems, a free interaction of resources, and a maximum use of professional skills, we believe that there has been a developing pattern of social-service effort. Some of the specific applications of the philosophy underlying our work are generic to the whole of our social-service endeavors. Professional and semi-professional disciplines have covered themselves with hard-earned individual achievement. The demands of people everywhere for these services call for the effectiveness that develops out of unity of purpose, method, and goal.

There are many problems inherent in the processes described. These might have been given a more detailed examination, but, principally, it has been the purpose of this paper to suggest an orientation rather than to present a detailed analysis of the process.

A NURSING COURSE AS AN AID IN THE REHABILITATION OF WOMEN MENTAL PATIENTS

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AN interesting experiment was conducted at Philadelphia State Hospital, Byberry, Pennsylvania, in the rehabilitation of women patients who would soon be well enough to go home on trial visits. Through a volunteer worker, Mrs. Percy Madeira, Vice Chairman of the Home Nursing Committee of the Southeastern Pennsylvania Red Cross Chapter, and the medical staff at Philadelphia State Hospital, the decision was made that the American Red Cross home-nursing course is one of the courses that would lend itself to facilitating the period of adjustment from hospital life to home life by simulating actual home situations. The instructor selected to teach the course was a graduate registered Red Cross nurse, with twenty years' experience in psychiatric nursing, as well as a teacher's degree from the University of Pennsylvania.

Special permission to try the value of the course was obtained from National Red Cross Headquarters by Mrs. Ethel L. Taylor, Director of Nursing Activities of the Southeastern Pennsylvania Chapter of the American Red Cross.

The first classes were held for fifteen weeks on Wednesday afternoons, from 2 to 4 P.M., in a classroom at Philadelphia State Hospital. Fourteen students who were selected by the medical staff started in the class, and eleven received Red Cross home-nursing certificates after they had successfully completed the course. Of the three who did not receive certificates, two had to withdraw from the class on account of illness and one refused to attend the last five classes.

The heterogeneity of the class group made it rather difficult to use the teaching methods suggested for use in teaching the Red Cross nursing course. Twelve of the women were white and two were Negroes. Twelve were of American,

one of Russian, and one of Polish birth. Seven were married and seven single. Prior to illness, seven had been housewives; the other seven included a typist, a clerk, a proof reader, a hospital attendant, a school girl, a factory worker, and a laboratory technician. All age groups, from the 13–19 year to the 60–64 year, were represented except the 45–49 year group, the greatest number—four—being in the age group 50–54. Educational experience, as indicated by number of years spent in school, varied from three years to fourteen years.

As their hobbies, five of the women gave reading papers; three, reading books; three, needlework; and one each, art, music, and housework. As their reasons for taking the course, eleven stated that they wanted to be able to help care for ill members of the family; one wanted to become a nurse later; one thought it would be useful in everyday life and to others; and one felt that it was "progressive."

This was one of the first courses in Red Cross home nursing ever taught in a mental hospital in the United States, for the rehabilitation of patients in preparation for family and community life outside the hospital. No attempt was made to test or to check on the degree of mental deterioration of these patients by any psychological tests prior to these classes.

The patients showed a marked improvement in their personal grooming when attending classes. The anticipation with which they prepared for the next meeting of the class showed their interest in it. The members of the group were attentive in class and readily grasped the new skills that they were taught. Very little repetition was needed to develop an understanding of these skills in most of the class. As a group very little friction between their personalities was evident.

Great interest was displayed in the subjects of proper nutrition, adequate rest, and personal hygiene, and the part that these factors play in the recovery of ill persons. Many of the questions asked on these subjects showed a keen insight on the part of some of these patients into illness and how to help one's self in recuperating from an illness.

Reading assignments were difficult to use with the whole group, because of the great differences in age and education.

One member of the group had taken a course in Red Cross home nursing in high school and had retained most of the skills taught her. All students were assigned to some activity, such as caring for equipment, cleaning and setting up the classroom, and putting away equipment after class. All the assignments were carried out well under the supervision of the instructor. Most of the class took just pride in the good work that they did.

A slight deviation from the usual class routine was adopted and found to be very effective: a rest period of twenty minutes was given between the first and the second hour of class, in which refreshments were served, and this resulted in better attention during the second hour of class.

The standard course was taught. The equipment was planned to simulate as far as possible home conditions. Trays, bedside tables, and back rests were improvised out of cardboard cartons. The evaluation of the teaching methods used was determined by each student's giving a satisfactory demonstration of a nursing skill assigned to her. It is felt that this course was effectual, to an extent, in the rehabilitation of members of this class, as several of the women are now at home on trial visits.

An effort was made by the instructor to obtain assistance in developing or devising some means of evaluating the teaching methods and the results of this experiment. At the University of Pittsburgh, Miss Ruth M. Jones, R.N., gave her time and valuable assistance. A social-adjustment test was suggested to use in testing the amount of rehabilitation accomplished by these classes. The Babcock-Levy test was to be used to test the degree of mental deterioration of each member of the class. This test was to be conducted before the classes started and again when they were finished. This is a vocabulary test that requires much personnel and time to give.

Mr. William Ecchner, psychologist of the Philadelphia State Hospital, gave the Shipley-Hartford test to a group of patients who were selected to take the next series of classes of the Red Cross home nursing to be conducted at the Philadelphia State Hospital. This test will be repeated at the end of three or four months to determine if any improvement or deterioration has occurred in mental age, vocabulary

age, abstraction age, or in the conceptual quotient of these patients.

More exact data were obtained on this group than on the members of the first class. Twelve started the course, and eight finished it and were given Red Cross home-nursing pins and Red Cross home-nursing certificates. Of the four who did not complete the course, two went home before it was completed and two were too ill to finish it.

The homogeneity of this group is just as marked as the heterogeneity of the first group. All twelve were white and all were Americans. Nine were single, three married. Prior to their illness, three had been factory workers, two waitresses, two clerks, two houseworkers, and one a student; two had had no occupation. One was in the 15–19-year age group; two in the 20–24; five in the 25–29; and one each in the 50–54 and the 60–64. Educational experience ranged from three years of school to twelve years. One, in addition to ten years of school, had had a year and a half of nurse's training.

The hobbies prior to illness were reported as reading newspapers and magazines in seven cases, reading books in four, and reading music and history in one. Eleven of the twelve gave as their reason for taking the course their desire to be able to care for ill members of their families; the twelfth was taking it because she was "interested in health."

Four of these patients had been in the hospital for nine months, one for seven, one for six, two for five, two for four, and two for one month.

In the second group, Unit II—Care of the Mother and Baby and Family Health—was taught before Unit I—Care of the Sick. Classes were held for two hours twice a week in the morning and in the afternoon for six weeks. The young women in the class were quite interested in the care of mother and baby. The teaching methods were different from those used in the first class, in that each patient was given an individual assignment which she carried out alone and then she began gradually to work with the group on assignments. The women worked together congenially and adapted themselves very well to learning the skills taught. Much tact had to be used to guide the lessons along the lesson plan so that the desired work could be covered. The same

plan of an intermission and refreshments between the first and the second class hour was adopted to relieve any tiredness or restlessness of the group. In this way the attention of the group was maintained throughout each lesson and the entire course.

Unit I—Care of the Sick—with its group work, helped some of the more social patients to work with the group congenially. When asked to act as patient for the rest of the class, the one chosen was honored. Very little repetition was necessary to teach these skills to the group. Praise was given to all who learned a skill and returned the demonstration correctly. Many visual aids were used and very few reading assignments were given.

Evaluation of the teaching methods used and of the amount of material learned by the group was determined by assigning each student a nursing procedure to carry out, which she did competently and easily. Much emphasis was placed on improving personal appearance and correcting faulty habits of nutrition, sleep, and work. Improvement was noted very quickly in these patients. They enjoyed the class. One member stated, "This is just as if we were home the day each week in which you come here to teach us how to act at home."

At closing-day exercises for the classes, each student who successfully completed the course was awarded a Red Cross nursing pin and a Red Cross home-nursing certificate. Representatives from the Southeastern Chapter of the American Red Cross of Pennsylvania, the medical staff of Philadelphia State Hospital, the nursing staff, and the ward personnel were present, much to the delight of the patients. The informality of singing and refreshments, minus long speeches, helped to make the occasion a big success.

On February 23, 1947, the Sunday *Philadelphia Bulletin* published a story about this class. This also seemed to add to its therapeutic value, as the members felt they were being given recognition for their efforts. The more cheerful outlook of a member of the class who had completed her work is shown in a letter written later to the instructor, in which she stated, "I received my Red Cross home-nursing certificate, of which I am very proud. My family is very pleased that I have completed the course and is praising me for it."

Much work remains to be done for psychiatric patients, but this seems to be a step in the right direction toward their rehabilitation by using situations that simulate work and living situations in family and community life, so that the patient is taught to readjust himself to these situations satisfactorily.

Really to evaluate the results of this work, a follow-up study of patients' satisfactory adjustment in the home and in the community must be made by a social-service worker or a visiting nurse, to see whether the women are applying their learning in their homes. If they are found to be socially and mentally adjusted to life in the community, the course in Red Cross home nursing may be used as a valuable aid in the rehabilitation of women psychiatric patients, justifying the amount of work and the expense involved.

Much of the success of this program at Philadelphia State Hospital can be credited to the excellent coöperation of the superintendent, Dr. Sielke, and members of the medical staff, Miss Edgar and members of the nursing staff, and the ward personnel at the Philadelphia State Hospital. The interest and assistance given by Mrs. Percy C. Madeira and another volunteer worker, Miss Helen Eden, Vice Chairman of the Home Nursing Committee of the Southeastern Pennsylvania Red Cross Chapter, combined with the valuable assistance of Mrs. Taylor and Miss Collins, of the Nursing Staff of the Southeastern Pennsylvania Chapter of the American Red Cross, contributed greatly to the success of the program. It is hoped that, with the coöperation of more trained workers, this program can be used as an aid in the rehabilitation of women psychiatric patients for return to the community as useful members of their families and of society.

TALKING TO A CHILD

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AND

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WHEN introduced to a five-year-old child, many well-meaning and interested adults show the unmistakable signs of uneasiness observable otherwise only when a well-fed man is confronted with a tiger on half-rations. Time and again we have been amazed to see how inept many otherwise competent people become when they suddenly encounter a live young child.

For the past few years it has been our pleasure and our responsibility to have the care of a young nephew of preschool age and of more than ordinary attractiveness to schoolmarms, store clerks, waitresses, college professors, and lively college-student baby-sitters; and because much of our time has been spent in an almost exclusively adult world, our experiences with problem adults have been wide and varied.

We have so often watched an adult meet our family group, at home or in some public place, only to have the entire meeting end in a social fiasco through no fault of the child, that we have come to realize that a double educational program is necessary: not only must a child be trained to meet other children and adults gracefully, but a great many adults need help in meeting and talking with children.

Mutual panic, however, is but one of the many problems encountered when a child is introduced to an adult acquaintance. Far more insidious than those who are struck speechless when confronted with so unfamiliar a phenomenon as a young child are the garrulous adults whose long reaches of memory into their own childhood days have grown dim and romantic. They insist upon taking over the whole show from the moment they cast their eyes upon "the little darling," toy with the delicate parent-child relationship for a moment, and then flounce off, leaving us with a youngster

who requires an hour of heavy handling before he becomes a reasonably civilized creature once more.

It has come to be no unusual experience for us to be sitting in a restaurant during a meal with everything quite under control, only to have some well-meaning stranger walk up, ruffle the child's hair with a loving hand, make sundry remarks as to where he got his lovely curly hair, what beautiful brown eyes he has, what perfect manners, and so on—with half of the people in the room beaming approval—and then, well satisfied with her work of destruction, walk out. Before this session of appreciation, we were enjoying our food and each other's company. Now the well-behaved boy, who had been taking a healthy interest in his food and in his surroundings, has been transformed into an excited show-off, and the rest of the day is on precarious ground.

We have had our friends, and even total strangers to whom we had just been introduced, anxious to show their sincere interest, suddenly grab the child by the hand and lead him into the nearest drugstore to buy him an ice-cream cone, while we, not wishing to be rude, miss our street car and our appointments, to say nothing of having the youngster emerge with messed clothes and a ruined mealtime to come.

We have known others to carry a liberal supply of candy or gum in their pockets to give to the youngster the moment they see him. "Go on and eat it. Your aunt won't mind!" They seem to assume that it is possible to gain a child's affection by training him, like a horse, to come for a lump of sugar.

What, then, you ask, *should* an adult do when he meets a youngster? Good adult behavior in the company of a child is far more conspicuous for its absence than for its presence. If an experienced adult greets a friend who is accompanied by a child, the youngster is recognized as part of the group, but he does not dominate it and, after the meeting, he should not require special handling.

Above all else, remember that when you meet a child you are meeting a person with definite rights as an individual. He is not a toy or a thing. Remember this, and address the child as a person. Don't stick your thumbs into his ribs to make him hysterical. This kind of romping, although it has its place in intimate child-adult relationships, is diffi-

cult to keep within reasonable limits, for it usually is impossible for the excited child to recognize just where the socially acceptable boundary of such activities lies. He becomes quite unable to stop, with the result that what you have started as innocent fun almost invariably changes the youngster into an irritating nuisance who persists in interrupting your attempts at conversation with his parents, the ultimate end being, almost inevitably, punishment for the child. At best, such skillful handling is required to keep activity of this sort within bounds and so long a period is needed to resettle the child into his normal course that horseplay has no place in casual meetings.

Don't talk baby talk! In spite of the fact that you know better, you probably do it more often than you think. It is an insult to any one to be taunted with his own imperfect speech. The child wants to learn *your* way of speaking, not to see how well you, a grown-up, can imitate and mock his infantile pronunciation.

Don't try to be silly. When confronted with a child, most adults are silly enough, without deliberately using silliness as a form of entertainment in an attempt to cover their own real inability to deal with the situation. Say what you have to say to the youngster, and then stop.

When you meet an adult with a child, it is probably best to address your first remarks or greetings to the adult. Then turn to the child, say a few words of greeting, and, if you wish, ask about some activity of interest to him and wait for his reply; then turn to the adult and say what you have come to say. Sometimes it is possible to say to the youngster that you want to talk to his mother for a few minutes now and that you hope some time to come for a real visit and talk to him about all those other things. Do not try to carry on a double, parallel conversation with both adult and child at the same time, interrupting each alternately. But, whatever you do, don't try to ignore the child. It is discourteous, and with most children it simply can't be done. He will go through his entire repertoire of tricks to gain at least some little attention.

No matter what your relationship with the child may be, never forget that he is under the care of the parent or other regular guardian. This adult is responsible for the behavior

of the child and for his routine and he, therefore, must be in full charge. It is a gross unkindness to subject a child to divided authority. "Never mind what your mother says. Here in my house you may do so and so." Never have words caused more ill will between adults, particularly between parents and grandparents. And never have they been more disturbing to the child, since he now no longer knows which voice to obey. In dividing his source of authority, you give him an opportunity to disobey with temporary impunity, but at the same time you are loading his conscience with a sense of guilt for doing something that he knows to be wrong or that at least does not have his parent's approval. It is easy to say, "Ask your mother if you may," and it pays dividends in parental good will.

Most parents are sincerely concerned about their child's welfare, and the restrictions that they place upon the youngster's activities are designed to protect his well-being. What seems to you an unreasonable prohibition may have been proven to them by bitter experience to be an essential safeguard. Most parents recognize, too, that occasional variations in routine or well-chosen treats are not only permissible, but desirable, and they are glad to allow the child as much freedom as they believe he can enjoy without serious unpleasantness now or later. "Here is some candy for you. Ask your mother whether you may eat some now or whether you may take it with you," respects both the personality of the child and the integrity and authority of the adult who is responsible for him.

All this, however, does not mean that you need to talk down to a child. Speak to him at his own level of understanding about things that interest him and in terms that he can comprehend. Talk about things that he has done or that he likes to do. Direct attention, not at the child himself, but rather at his interests or activities.

Particularly, in evaluating and commenting upon his work, his drawings or coloring, his efforts at carpentry, his attempts at writing, or the music that he has played or sung for you, it is always well to focus his attention upon *what* has been done, not upon how well *he* has done it. An honest piece of work, at any level of accomplishment, deserves honest appreciation; and comments upon the work or upon the object

leave the child free to participate in the activities at hand or in the conversation, instead of forcing him into bashful and self-conscious silence.

Do not embarrass a child by criticizing him for something beyond his control. "Why didn't you come to visit me as you promised?" when the visit or non-visit was not of the child's choosing, is an unkind question that can have no answer. Nor does the mere fact that you have once given the child a present entitle you to the rôle of inquisitor. In any event, a question like "Why aren't you wearing the nice sweater I knit for you?" should be addressed to the parent, not to the child.

If the youngster is being deprived of some privilege or is on punishment of some sort, your direct sympathies with him—at least an open expression of them—are out of place. Don't tell him that his dad and mother are mean to him, thus dividing his loyalty when it already is at low ebb. If you must comment, remind him that he wants to grow up to be a pleasant, happy person and assure him that his mother punishes him only because she likes him and is anxious for him to grow up to be a fine boy. This attitude *must* be your reaction *before the child* even if you disagree with the parent as to the desirability of her procedure. If you feel strongly on the point and are not afraid to encounter an irate parent, later and *in private* discuss the problem of punishment with the parents—but *never* in the child's hearing.

Whenever you have anything to say to the parent that you don't wish the child to hear, don't attempt—ever—to discuss it in the youngster's presence. Even though he seems absorbed in his play, don't be so foolish as to think that you can talk about him, even in a foreign language, without his realizing that he is the subject of conversation. Even to a dull child your gestures, significant looks, and tone of voice will be revealing; and if the child is bright, he probably will understand the tenor of the conversation as well as the adult to whom you are speaking. Even worse, he may not *quite* understand your meaning, and will then fill in details from his own vivid imagination and fears. Half-understood ideas and misinterpreted terms have been a source of serious worry to many a young child, particularly since even

the most fortunate youngster usually has some phase of life in which he feels dangerously insecure.

When the child is ill or when he has been hurt, it becomes doubly difficult and triply important to keep conversation on a matter-of-fact basis, sympathetic, but casual. Sympathy does not require violent expression of emotion or sentimentality. Remember, too, that the adult's attitude is all-important in determining the child's reaction to his injury and in preventing the arousal of fear which can increase pain to the point of terror. Because of his limited experience, the child evaluates his injury or peril primarily by watching and copying the reactions of those about him; and hence by poorly chosen expressions of sympathy or by inviting him to recite and re-live all the sad details of his trouble, you actually increase his pain. How often one hears, "Oh, dear! Oh, dear! How did you bang up my little sweetheart like that? Tell me. How *did* you do it?" How seldom, "Well, you had a little bump, didn't you? I see you have on a nice clean white patch." And rare, indeed, is the adult who has the good sense to drop the subject at this point and casually introduce some more absorbing topic of conversation.

Children learn by observation of good procedure and correct adult behavior more than by precept or by being forced into embarrassing situations. If, when he is introduced to you, a child is shy and does not come out from his corner or from behind his mother, he cannot be forced and probably should not be coaxed. If you simply go through your own part of the introduction casually and permit the child to respond in his own time, he will probably soon lose his shyness and an all-around pleasant relationship will follow.

A philosopher once said that, when dining, it is best not to talk overly much about how one should eat, but just to eat as one ought. It would be well if this principle were observed more generally in our dealings with children. Do not constantly tell them how to do this or that, but do *you* do these things as you would have them copied.

Children *can* be fun. They can be a pleasure to themselves and to all they meet. They can also be a source of embarrassment and annoyance, of humiliation and man's deepest grief. Children respond to all the examples they

see. They want, earnestly, to learn to live in an adult world; they look up to all grown-ups, therefore, to teach them how to achieve this goal. Most adults, we believe, have the necessary consideration and willingness to help. With a little thoughtfulness they can also acquire sufficient skill in child-adult relationships, so that this learning can take place easily and effectively; and the process will then be a pleasure both for themselves and for the child.

Although the major responsibility for child care and training unquestionably rests upon the family, it is, nevertheless, the inescapable responsibility of every adult, simply because he is an adult and a one-time child, to do all that he can to help each child he meets in his effort to achieve maturity.

REMARKS ON THE INTERNATIONAL CONGRESS ON MENTAL HEALTH *

MR. ARTHUR H. BUNKER (Vice President and Chairman of the Executive Committee, Lehman Corporation, New York City): The first speaker to-day is an associate professor of psychiatry at Cornell Medical College. During the war, he concerned himself very greatly with the difficult problem of rehabilitation and reintroduction to life of the military man who was a dischargee from a mental institution. After the war, he devoted himself to other phases of the rehabilitation question and the vocational adjustment of people who had been dismissed from mental hospitals. Dr. Rennie.

DR. THOMAS A. C. RENNIE: Mr. Bunker, General Eisenhower, distinguished guests, and gentlemen, in London in August of this year, a group of scientists will meet for ten days at an International Congress on Mental Health. It is to tell you a little about it that we are here, and we hope that we will enlist your interest and support in it.

Now this is a unique kind of venture, a unique scientific gathering. There probably has never been anything like it before in the history of science, because delegates from 47 nations will come together at that time with the desire to share ideas, to get down to fundamentals on what we can agree upon that is significant for mental and personal health, to map out blue prints for action, and possibly to spearhead desperately needed activities in this vast area.

Now, these will not be psychiatrists alone. There will be all kinds of people who are interested in mental-health matters. There will be social workers, psychologists, teachers, and educators; there will be nurses; there will be employers and industrial experts and the clergy. It will be a joint meeting of all people who have a stake in mental health, and it is anticipated that some 2,000 people will meet in London for this congress.

* Delivered at a luncheon given by the International Committee for Mental Hygiene, May 5, 1948, at the University Club, New York City, in support of the International Congress on Mental Health, held in London in August, 1948.

Again, this is not an ordinary kind of scientific meeting. It will not consist merely of ten days of reading papers or presenting scientific research. There is a vast amount of preparation already under way for this significant congress. In this country, for example, there are 180 groups at work now, and they have been for many months. There will probably be another 100 such groups working in the other nations. And what are they working on? The following things:

They have sat down together, these people from many disciplines—they are thrashing out their conceptions of what is basic in such matters as: What has war done to children? What constitutes wise rearing of children in order that they may grow into emotionally stable adults? What is group prejudice? What are its laws and how does it operate? Why do we have hatred of minorities? Why do we have misunderstanding among peoples and states and nations? What light can we from our special sciences throw on international relations? What is the rôle of the worker in industry and what is its relationship to mental and emotional stability? These and literally dozens of other topics are being carefully and thoughtfully explored now. In addition, three weeks before this congress, there will go to London one delegate from each nation, to work at sifting and sorting, studying and preparing conclusions, which will then be presented to the entire congress.

Let us look briefly at one aspect of this kind of deliberation—that which has to do with the emotional status of the average worker in industry. It is reliably estimated that every family in this country has one or two people employed. That means that from fifty to sixty million human beings are regularly employed in occupations that either do or do not supply some kind of emotional satisfaction. Now, so significant a thing as a job in the life of a human being is obviously important not only for his own emotional well-being, but also as it reflects on the happiness of his family; hence it is important to society in general. Any area of a man's life that takes so large an amount of time out of his life as his job does throughout so long a period of his lifetime is obviously of profound significance for his mental well-being. While it is true that the worker takes with him into the job the problems that originate outside it, it is

equally true that the circumstances under which he works are of profound significance for his well-being.

Now, in our democratic and capitalist society, industry operates on a particular principle—namely, that materials plus technology plus the worker plus management enable us to produce goods at lowest cost and henceforth result in a higher level of living for all. The second law is that the value of goods minus their cost of production equals profits. With our particular genius, we have solved every aspect of that law except one, and that is the worker-management problem. It seems to many people looking on from the outside, and to many from the inside, that our handling of the worker-management problem is on a pre-scientific level. We have failed, therefore, to understand or to solve this vast problem of human engineering. There is no reason to believe that if with our genius and intelligence we can solve the technological problems, we cannot also solve this problem in human relations, if we devote the same amount of energy, thought, and study to it.

Some solution is significant for a number of reasons. It is reliably estimated that somewhere between 20 per cent and 40 per cent of all workers in all industry will at some time in their lives, however brief or long, be unable to stand up to the physical or the emotional stresses of their job situations. It has been reliably estimated that 70 per cent of all human beings who fail in jobs do so, not because of lack of intelligence or aptitude, but because of emotional handicaps that get in the way. It has been clearly and reliably estimated that from 30 per cent to 35 per cent of all workers are suffering primarily from emotional disability. Conclusions are obvious. Where one has so large a segment of emotionally unhappy people, obviously we are going to have discontent, strife, lack of understanding, and absenteeism. We are going to have that interesting group of people who regularly have accidents. In 1941, for example, it was estimated that four million people in this country in industry suffered either a serious accident or death. It has been said that 80 per cent of such accidents are preventable; it has been said also that 50 per cent of them are primarily motivated by emotional forces in the individual who suffers the accident.

These considerations, therefore, are, as you can well see, significant and important considerations. Now, if we had no pattern for an attempt at their solution, we might talk in vain about them. But these same kinds of emotional situation existed in military life, and it was soon found that a few simple things made a world of difference in the morale in the military situation. Where good morale existed, men did not break down so easily, and, conversely, where poor morale existed, the incidence of emotional breakdown was high. Military leaders discovered that morale is well sustained when the officer cares about the individual man under him, that morale is enhanced when a man's aptitudes are carefully studied and tested and when some kind of job-fitting process is carried out to permit him to function at his maximum level. They found that morale depends on such factors as a sense of group cohesiveness, a feeling of belonging to the same team. These are factors that can be created.

It was very interesting that in Great Britain after the war they took those officers who had had experience in education and counseling in the military and put them back into the industrial situation—gave them a specific job to educate foremen to carry out group discussions within industry—taking time from the work hours, with the knowledge of management, to let these men talk out all kinds of things in a free situation. As they progressed with so simple a procedure as attention to the individual needs of the man, production increased; morale was appreciably heightened.

Now, this is only one pattern of material that will be discussed and thrashed out. There are groups preparing further material on this subject now. I can tell you with all confidence that this congress has a unique opportunity to bring scientists together from many countries for a sharing of information among themselves, and an opportunity for them to get to know and to understand the needs of different people. It will lead to the formulation of very specific principles that deal with the emotional and mental well-being of people.

Perhaps more significant in terms of action, it will lead to the formation of a World Federation for Mental Health. This World Federation will then make application to the World Health Organization and U. N. E. S. C. O. to be the

official consultative voluntary agency in the field of mental health. We have, therefore, a method of implementing our work. This is not only talk. This has promise of effective action.

It is for these reasons that I have the temerity to say to you: This is a significant adventure that concerns you as well as it does the professional workers in the social and psychological sciences. Before Dr. Menninger and the others get through, I hope we shall have enlisted not only your interest but your warm support.

Mr. Arthur H. Bunker: The next speaker has devoted all of his money and his life to the problems revealed. He has received all the academic honors that come from that field of work. He is at the moment President-Elect of the American Psychiatric Association, and President of the American Psychoanalytic Association. Some twenty or twenty-five years ago he and his brother started a clinic which now has a national and an international reputation—the Menninger Clinic.

When the war broke out, Dr. Will Menninger, here, became a brigadier-general and was placed in charge of all neuropsychiatric problems for the army. He was able to change methods of treatment to make them more expeditious; he was also able to keep pace with the body of available scientific knowledge as to those problems. That in itself was a great achievement.

As soon as the war was over and General Bradley was put in charge of the Veterans Administration, he asked the two Menninger brothers if the Menninger Clinic would assist the Veterans Administration in making the Winter General Hospital at Topeka a training center for the urgently needed additional psychiatric and ancillary personnel. As a result, to-day the Winter Veterans Hospital has become one of the most outstanding psychiatric training centers in the world. Dr. Menninger.

Dr. William C. Menninger: Mr. Bunker and gentlemen, I am always glad of a chance to take on the tough assignment of trying to talk about the professional field of psychiatry to a group of people who I assume may be skeptical. I am aware of the fact that psychiatrists are often conceived of as long-

bearded, strange birds who may be reading your mind and who are suspected of proposing some new "phony" idea. As a matter of fact, it is not generally known, even to many intelligent people, that psychiatrists go through the whole gamut of training in medicine and surgery before they come to the field of mental health. Traditionally, the job of the psychiatrist for many, many years had been pretty largely limited to diagnosis and treatment of mental ill health. Within the last few years, however, that concept has materially changed, in part because of the wide acceptance and recognition of psychiatry on the part of the public. The viewpoint of the public has changed to recognize that how one *feels* is important and that emotional factors in adjustment are extremely important. Psychiatry to-day is concerned with how people think, feel, and behave. When the thoughts or attitudes or behavior become damaging to the individual or to the environmental situation, the problem becomes the object of our special interest.

We in the army became aware that one out of every eight men who came to the draft board had to be rejected for mental illness. The military forces were naturally reasonably alarmed when we faced the fact that out of our total losses of man power in the army, more than 50 per cent were for personality disorders. If we add the losses in the navy, 700,000 men in one year were lost from military service because of personality problems. The armed services had to take cognizance of this terrific loss and do what they could about it. We face the fact now that 62 per cent of all patients in the veterans hospitals are there because of psychiatric problems.

Of course we wonder why this has come about. Why did it come about? Was it a strange and new phenomenon? The fact remains that we cannot assume that it was a strange phenomenon. We know that the same thing happened in the other armies. We have definite figures that are very comparable to our own, to show the same mental and emotional disturbances in the army of the U.S.S.R. It only leads to the obvious conclusion that the emotions men have are the same in Russia and in America. If we could understand these emotions and how to deal with them, we could feel we were getting somewhere. This situation that we

found in the military service, of course, was accentuated by the men's being in the armed forces and in the stress of actual combat, but the same types of emotional disorder constitute a major problem in civilian life. We must face it. I am not an alarmist about it; it is much more practical to get the facts and make aggressive, deliberate efforts to correct the situation.

I mean specifically that half our hospital beds in America are devoted to mental illness. That fact is often amazing and surprising to a group of laymen. Statistically, about 50 per cent of all patients who go to doctors have emotional problems. These are expressed not only in attitudes and behavior, but in physical symptoms—in the heart, the limbs, the stomach, or the aching back. There are many, many evidences that we live in a sick world. We have hit an all-time record of crime which is costing us about ten billion dollars a year in this country. We have an increasing amount of delinquency in every community in the country. We know that our divorces have doubled inside of six years—whatever that means. If we are going to face unpleasant and disagreeable facts, many Americans make other Americans extremely unhappy by discrimination and prejudicial practices. We know that the housing situation is making approximately three million families live doubled up at the present time—and in terms of mental health that is taking a toll.

We cannot ignore these facts because they are there. We wish we knew why, from a scientific psychological standpoint, these things occur. If this sorry state of affairs occurred in business, there would be an indefinite and unlimited amount of research done about it. Actually, for every dollar spent in medical research, four hundred dollars is spent in industrial and business research. If we limit the figure to research in the field of mental health, *three cents* is spent for psychiatric research for every *four hundred dollars* spent in industrial research.

What does it mean? We have learned to annihilate space, we know how to wipe out whole cities, but we have not learned how to get along with one another. Our technological advances are so far ahead of our social advances that we must expect these emotional maladjustments and disharmonies to increase. You and I know that even our college youth to-day do not

know whether they are going to be in college next year; that, too, is taking its toll. I don't think any one of us can be free from the feeling of unrest and unhappiness as it exists in the international situation. We cannot ignore the fact that it causes stress for many people.

I remember hearing General Eisenhower, on a previous occasion, say, "No one can win a war any more; everybody loses." It is a valid question whether, if we have another war, civilization may not even be wiped out. We must learn a lot more about ourselves. Other people have got to learn about us and we have got to learn about them if we are to make progress in improving human relations and international coöperation.

This London congress is an heroic effort in trying to pool our scientific information about why we behave and act as we do. One of the points of special interest is the possibilities in the prevention of war. We know from experience that if we can get good people together and have them sit down across the table and talk about problems, we can straighten out lots of difficulties if those people have convictions based on knowledge. This congress is based on that assumption. One of the hopes is that maybe we can come up with some new ideas and approaches. God knows we must. We have tried other ways. The world is further behind than it was at the beginning of the last war. This is another chance. We have got to work out solutions; if we don't, then we are sunk. War begins in the minds of men. Social, economic, and political factors enter in, to be sure—but it is the way we think and millions of other people think that is going to make a war or prevent one. Are we going to be able to prevent a war? One of the main objectives of this conference is an attempt at that problem.

Mr. Arthur H. Bunker: Our next speaker needs no introduction here or anywhere. General Eisenhower.

General Dwight D. Eisenhower: After two such erudite discourses, anything I have to say can scarcely be considered more than punctuation marks. But I should like to start off by saying that my interest in this movement is evidenced by the fact that I have had this date on my calendar ever since I first heard of the effort to hold the luncheon. And

I assure you that if any one of you wants to get into a new world and become busy and somewhat bewildered, just attempt to become a freshman college president and then see if you have time to go to many luncheons.

It is possible that out of war experience I can bring to you, though, a few practical examples of what happens to us if we neglect this great field of endeavor that has just been explained to you by these two speakers. In the late fall of 1944, we became desperate for replacements for the infantry divisions on the Western Front. We were informed that this was because, in the previous summer of 1943, the United States had not been able to fill its draft quotas. We were reduced to desperate measures. We had to go through our entire service of supply and take out many men occupying key positions, but because they had healthy bodies and minds, we had to attempt to retrain them in a few weeks to get them into the battle line. We combed the air forces in the same way.

The United States, which we were accustomed to think of as an unlimited reservoir, could not produce enough men. Yet at the same time we were told about the hundreds of thousands of men who had been rejected for mental deficiencies. I am told that by the end of the war two million Americans had been rejected for these mental deficiencies. These two facts certainly bring out this: The man power of the United States is not inexhaustible. It is one of our most treasured assets and one that we must do our utmost to maintain, if we are going to do anything about a future crisis and future emergencies.

I think this problem was emphasized to me in a most dramatic fashion in visits to the front, and later to the rear, to hospitals of particular types. There is no American who can visit the front lines—and I know some of you gentlemen have—without coming away with a deep sense of humility at seeing young Americans, unshaved for a week, blue, cold, muddy, unkempt, undergoing everything with an uncomplaining smile or a grin or a wisecrack when you come around, saying, "Everything's all right in the First Division, General. Don't worry about us." One comes away with the feeling that the young American can do anything.

Then you go to the hospitals in the rear for the psycho-

neurotic cases. There you find young men who are at least all right in their outward appearance—they are cleaned up, shaved; they look strong. Why is it those hospitals are overflowing? I remember my first shock was when I came on this problem definitely at the first camp I visited, where there were 6,000 young Americans, there for mental deficiencies. They couldn't take the front lines.

To touch on a point that was made earlier, about the value of direct human contact—dealing with each man as an individual, twice in the war after I had sat on a young fellow's bed, joking with him and putting my hand on his shoulder, he said, "General, get me out of here. I want to join my outfit." Apparently it was the first time in his life that a man had taken the necessary time and made the effort to treat him as a human being and talk to him about his own problem. And then he said, "General, I want to get back and join my outfit."

You must not think of these people as just some sort of unfortunates wandering on the docks in New York—or wherever it is one roams in New York—you understand, I don't know. They are not—they are people like you. I saw a major general, one of the finest athletes of his time, one of the most brilliant men of his time, definitely break—and he broke because he could no longer sustain the responsibilities, the agonies of combat. As a matter of fact, I saw more than one, finally, but this one was a special case, where the man could not talk to me without shaking in a violent manner.

Later, after the war was over, we were astonished, as we went about Europe, at the lack of information about America in those countries. Of course, late information from America was denied them by the Nazi-controlled publicity, and that was understandable. But to go back to the most significant parts of our history, we found Frenchmen who had never heard of Lafayette. We found intelligent British officers who asked me, "What was this war of 1812?" Significant facts in our history are often absolutely unknown to them because they were not important to them, although they were to us. Likewise, there are many facts of their history—although not in any such degree—unknown to us.

Going on the theory that a man is most frightened by

what he doesn't see, and of the unknown—we are all frightened of the dark—it was easy for us to find the old truism that if all the people of the world understood each other, there would be no danger of future war. And I do believe that now.

These gentlemen who talked to you to-day are trying to find out *why* we don't understand the problem. It is not enough to say that a few men in the Kremlin are going to deny a great percentage of the earth's population the chance to learn. It is not enough to say that our motives, which we think are altruistic and pure, and which are at least sensible and conform to our own moral standards, are certainly misunderstood in South America—as those of you who have traveled down there will know, of course. Now we must find out *why* we are misunderstood.

I say again that if the people of the congress that has been described to you can achieve only a small step toward a beginning of the solution to this problem, not only will we be bringing about a most tremendous upsurging in prosperity and unity at home, but we will be doing a very great deal to eliminate the causes of war. I repeat, if in the measurable future we don't find some way to eliminate the causes of war—which is the only way that war will be truly eliminated—our grandchildren are going to find this world a most unhappy place in which to live, and, gentlemen, that is important to me—I've lately had a grandson. Thank you very much.

BOOK REVIEWS

MENTAL HEALTH IN MODERN SOCIETY. By Thomas A. C. Rennie, M.D., and Luther Woodward. New York: The Commonwealth Fund, 1948. 403 p.

In this book, the authors have made an important contribution to two major areas of mental-health literature. Part I presents a clear-cut and well-organized record of the mental health and psychiatric services developed by the armed forces during World War II; the second and third sections contain specific and practical applications of these war-time lessons to present peace-time problems.

Part II is a brief, but timely reminder that the psychiatric residuals of war remain with us in terms both of veterans and of civilians who carry the "unseen wounds" induced by war-time stresses and strains. As the authors point out, this adds urgency to our need to organize for more effective prevention and treatment of mental ills. Under the headings, *Research, More and Better Facilities for the Treatment of the Ill,* and *Recruitment and Training of Personnel,* the major inadequacies of our present program are touched upon. The National Mental Health Act is evaluated in terms of the contribution it can make to remedying deficits in research and man power.

In this connection, it is unfortunate that the authors were under the impression that the National Institute of Mental Health, authorized by the Act, is to be operated in connection with the Naval Hospital at Bethesda. It will actually be a part of the Public Health Service's National Institutes of Health and consequently will draw its research material from the total population and not from the limited segment eligible for treatment at the Naval Hospital.

Approximately three-fourths of the book—and the section that gives it a unique place in mental-hygiene literature—is devoted to "Sources of Help in Treatment and Prevention." If every physician, parent, teacher, religious leader, business executive, and labor leader read this book, and particularly the special chapters addressed to them, it would be very helpful in laying the groundwork for a genuine public-health approach to mental ills.

Recognizing that the mental and emotional disturbances of millions of Americans cannot wait for the elaborate preparation of all the personnel needed to deal with these problems, the authors have entered a field that few other professional writers on this subject have thus far trod. They describe precisely how the physician, the pastor,

the teacher, the factory foreman, the personnel director, and others can be helpful to disturbed people, not at some future date when they have had adequate psychiatric orientation, but in the immediate present.

The authors themselves have recognized the risks involved in including such material, but, as they point out, "it is in no sense intended to suggest that people without special training can become skilled therapists. It is offered to show how, within the limits of their several callings, many different kinds of professional people can contribute to the resolution of a national-health problem by giving those who consult them wise understanding, coöperation, and supportive action." These chapters are handled skillfully and are so readable that they should have an immediate appeal to the audiences they are designed to reach.

An equally valuable section of this part of the book is devoted to a review and analysis of the specialized contributions made by members of the various mental-health professions, particularly social workers and psychologists. These chapters should help members of related disciplines to understand each other better and thus foster the teamwork that is so essential to a successful approach to our mental-health problems.

Five objectives of mental-hygiene education are outlined by the authors in their concluding chapter: to "(1) develop a broad understanding of what constitutes health-mindedness at each stage of development, what the danger signs are, and what people can do to prevent psychological liabilities from becoming serious blocks to health and happiness; (2) develop increased appreciation of the dynamic quality of family living and of the special significance of health and happy relations in the childhood years; (3) bring about fuller recognition of the stabilizing influence of satisfying work and economic security and of the threat to mental health which lies in neglecting the personal, human values of a job and their importance to the worker; (4) acquaint the public with the potential contributions to mental hygiene which can be made by the physician, social worker, teacher and other professional persons; (5) outline the essentials of a healthier society with emphasis on the most needed changes and on the appropriate next steps to be taken by citizens."

Publication of *Mental Health in Modern Society* brings us closer to the attainment of each of these objectives. There has long been a need for this book which throws so much light on these important aspects of mental health.

ROBERT H. FELIX.

Mental Hygiene Division, United States Public Health Service.

HANDBOOK OF PSYCHIATRY. By Winfred Overholser, M.D., and Winifred Richmond. Philadelphia: J. B. Lippincott Company, 1947. 252 p.

This excellent book is intended for medical and college students, for nurses, and for the average man or woman who has mentally ill relatives or friends. The book is well written and is presented in simple language. There are numerous case studies to illustrate the common psychiatric disorders and emotional problems. Not too much emphasis is placed on mental mechanisms, however, and the authors are rather conservative in discussing some of the newer forms of treatment.

The relationship of psychiatry to psychology is well discussed. Psychiatry has not always been interested in the individual. There was a long period of time when its chief interest was not in man and why he was sick, but in the sickness itself. The authors state that they have attempted to present in simple and unsensational form the elements of the varied types of mental disease, their causes, symptoms, and prospects. Therapy is sketched in general terms only, for the authors did not wish to offer encouragement for self-treatment. In this respect they have succeeded admirably.

There is a rather interesting chapter on the modern hospital. The authors endeavor to describe what goes on behind the doors of a mental hospital, with discussion of the important forms of treatment, such as hydrotherapy, physiotherapy, electrotherapy, psychotherapy, and some of the newer forms of shock therapy.

There is a good description of the common psychoses and the mental deficiencies, with particular reference to etiology and symptomatology.

The treatment of psychoneurosis comprises the bulk of psychiatric practice. It is estimated that some 30 to 50 per cent of the average medical practice is composed of such disorders. In most neurotic states, the sufferers are not incapacitated and may be capable of going to work. They may be unhappy and dissatisfied, and they may be aware that there is something wrong, but they do not know what it is. Very often they think it is physical, and they may have many types of complaint and seek one doctor after another. In industry they constitute the absentees who are always losing time because of illness. At home they are the chronic complainers suffering from all sorts of pains and nervous spells, and unable to take their full share of responsibility, although they frequently outlive the other members of the family.

This book could not fail to show the impact of the recent war. There is an excellent chapter on "mental breakdowns in war time,"

and a discussion of civilian morale and of the various types of personality that fail to adapt to military life.

Dr. Overholser is recognized as an authority on criminal psychiatry, and he presents a good outline on the relationship of crime to mental disorders. The psychiatrist is interested in the motivations of crime, as he is in all human behavior. Mental disorders are highly individual matters, and any individual's psychosis may lead to almost any type of criminal behavior.

The authors give credit to the outstanding work of such pioneers in the field of mental hygiene as Dorothy Dix, who almost single-handed succeeded in arousing the public conscience and bringing about the establishment of many psychiatric hospitals, and Clifford Beers, who organized the mental-hygiene movement in this country.

The book has been written in the belief that the layman wants to know more about psychiatry, and that, rightly informed, he will lose much of his fear of mental disorders.

LEO MALETZ.

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THE CASE BOOK OF A MEDICAL PSYCHOLOGIST. By Charles Berg, M.D. New York: W. W. Norton and Company, 1948. 260 p.

It must be the unexpressed wish and hope of every psychoanalyst, as he sits in his office hour after hour unraveling human material, some day to put this "wonderful" material, together with some original comments and observations, into a book. Few, however, realize this ambition, for it takes much more work than is ordinarily supposed to put a case before the public. One has to sift an immense amount of material to select judiciously what is needed for the purposes intended. It takes not only material, but a particular type of gift given to but few to be able to put this material in presentable form.

To this fortunate few belongs Dr. Charles Berg of London, who is not only a highly competent and experienced psychoanalyst, but a gifted writer as well. The essential features of twenty-odd cases are presented in a highly readable form. There is little repetition, each case being different from the others. There are cases of asthma and conversion phenomena, of anxieties and depressions, of impotence and frigidity, of morbid fears and compulsions, of war neuroses and civilian neuroses, of feelings of inferiority and the psychic defenses against them.

With respect to the latter reaction, the so-called "inferiority complex," Dr. Berg has not been able to confirm this as a clinical entity, but regards it quite correctly as flowing out chiefly from guilt feelings. Throughout there is emphasis on the original Œdipus

situation, on conscience and its disturbances as evidenced by guilt—and by guilt the psychoanalyst means not conscious guilt, which is remorse, but unconscious guilt of the type we find in a patient who feels guilty without knowing why. It is this ubiquitous guilt that the reviewer sees as mankind's greatest plague—one that is responsible for our inferiorities, for our loves and hates, for suicides and murders, for much of our insecurity, for interpersonal strifes as well as for internecine, even international hostilities.

While the trained psychoanalyst will find little in this book that he has not known for years, the non-analytic practicing psychiatrist, the large number of psychologists, clergymen, nurses, social workers, as well as many of the lay intelligentsia who have more than a general interest in the psychoanalytic approach, will profit greatly by it.

It is interesting that although physical and conversion phenomena are frequently mentioned, the word psychosomatic, of such popular use in the United States, is mentioned nowhere, either in the index or in the text so far as the reviewer could see. There is a good and entirely adequate index.

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PAINTING AND PERSONALITY. By Rose H. Alschuler and La Berta Hattwick. Chicago: University of Chicago Press, 1947. 590 pp.

The two volumes of this work comprise one of the most completely described experimental analyses yet published of a projective method applied to young children. They represent the most attractively presented research report in child psychology this reviewer has had the fortune to examine.

Volume I contains the findings and interpretations, material pertinent to the experimental method and the research forms used, including one complete sample case analysis, and 120 plates, most of them in full color—reproductions from the basic data of the study (easel paintings by young children). Volume II contains brief biographical summaries (from 200 to 400 words) of the children studied. There are also 56 detailed tables, presenting all the statistical findings of the study. The authors and the University of Chicago Press are to be complimented on the attractive arrangement, format, and typography of the work.

The study was devised to explore the possibility that a child's easel paintings, done freely and apart from adult criticism, will be directly expressive of his individual personality. Other play products were studied, including crayon work, clay modeling, block-building, and dramatic play. Results on these media are reported

incidentally, and principally as they conform to the trends noted in child paintings.

The painting activities of 150 children, ranging in age from two and a half to five and a half, were observed closely for one school year, with an intensive follow-up on 20 cases for another year. (In the Appendix to Volume I these figures are given as 149 and 21.) These children came from eight nursery schools, covering a variety of social groups and income levels. No socio-economic data are reported, though certain broad trends are noted—*e.g.* (p. 176), "Children in suburban communities tended to show more repressions and restraints than urban children."

The basic records for the study consisted of a collection of all the paintings of each child, a collection of teachers' daily logs on each child, a number of full-day diary records by outside observers for each child—which were repeated if they did not conform to the classroom teacher's opinion of the child—and anecdotal records.

Analysis of data was conducted by individual as well as group methods. A child's paintings for a given day were compared in detail with his recorded behavior for that day. The authors state (p. 186):

> "As product after product was treated in this way, we found certain characteristics of products and certain characteristics of behavior in a given child which consistently paralleled each other. We found certain types of change in product paralleled by certain consistent trends which furnished clues as to the possible meaning of the given set of paintings for the given child. It was the appearance of the same consistent trends in several children that furnished a springboard for the quantitative study."

The basic sets of variables—personality qualities and painting performances—were quantified on the basis of combination check lists and rating scales. The "A form" was made up of a long series of personality qualities. Two of these were filled out for each child at the end of the year—one by his teacher, and one on the basis of a careful study of all the accumulated observational and descriptive material. These two records were compared and "integrated." Where discrepancies occurred, the records were restudied in an effort to harmonize the judgments. Where evidence was lacking, the child was not evaluated on that item.

The "B form" was filled out on the basis of a product-by-product analysis for each child. The authors state (pp. 192–93):

> "In analyzing children's characteristics with products, we felt that evaluations based on the distribution of emphasis within each individual's own pattern were more meaningful than evaluations based on group comparisons. Accordingly, we have not tried to work out group averages and group distributions for such characteristics as use of red,

tendency to overlay, filling the page, etc., but have based individual ratings on intercomparisons within the child's own data.''

The final, or summary, A and B forms were then compared for each member of the total group, and results were reported in terms of percentages of coincidence, and significance of differences between percentages of groups of children showing different trends.

The most significant differences among nursery-school children are found in their abstract treatment of color, space, line, and form rather than in the recognizable subject matter of paintings. The writers state (p. 14); ''How these aspects of painting will be handled by an individual child seems to be largely out of the conscious control of the individual and to reflect general, and perhaps universal tendencies.'' Paint is a better medium than crayons for expressing inner feelings. (Finger-paint enthusiasts will regret that this study was limited to brush work.)

Not all children, however, express their feelings or conflicts in the same way—the same conflict may, indeed, be expressed in various ways. Chief among the recurrent problems reflected in the paintings is the conflict between the child's impulse to do as he wishes and external demands on him for controlled behavior. Common occasions for this basic conflict are a new baby in the family, parental emphasis on cleanliness, training in eliminative habits, and the sex rôle of the child.

The categories for evaluation of paintings lean heavily upon color, line, and form, with some attention given to space usage and spatial pattern rather than upon pictorial symbolism. Colors give the clearest clues as to the nature and degree of the intensity of the child's emotional life. Line and form give clues to (1) the amount of energy the child is expending, (2) the control he is exercising, and (3) the direction in which that control is operating. Taken together, color, line, and form represent the balance between the child's impulsive drives and his controlled behavior. Space usage and spatial pattern tend to give less a picture of the child's inner life than a picture of the child as he relates to and reacts to his environment.

Interest in warm colors (yellow, red) is associated with free emotional behavior, with a self-centered orientation, and is characteristic of normal nursery-school-age children. An interest in cold colors (green, and especially blue) is associated with highly controlled, overadaptive behavior, which is critical, assertive, or undemonstrative toward others. In many of these children unusual pressures toward control were exhibited by their parents. A preference for cooler colors comes naturally as the child grows older, as does desire to work with line and form.

Of interest is the authors' contention that children who were *not* outgoing or easily affectionate and who ordinarily did not prefer warm colors, did show an increased interest in red during periods when they were more relaxed and happy.

Line and form are used more frequently by older children as a normal developmental trend. The use of these characteristics presumably parallels the child's increased interest in relationships outside himself. Where color is the more basic, primitive interest, line and form represent a more mature, complicated, abstract reaction. Children interested in form tended to be more logical and less impulsive than those interested in color. Socially oriented children move rather quickly through a phase of interest in abstractly patterned work to representative drawing. Children who presumably had abilities along constructive lines persisted in varied and increasingly intricate abstract or structured designs.

As in color, certain forms have a definite significance. Straight-line vertical or angular strokes are associated with assertive, outgoing behavior, realistic interest, initiative for play, and negativism. These forms also increase with age. Curved continuous strokes represent more dependent, more compliant, more emotionally toned reactions.

Wet, dripping paintings paralleled concern over elimination problems. Children who put on paint sparsely and with a dry brush lacked confidence, were aimless, or miserly. Space usage and color overlay are also found to be quite significant for a variety of personality tendencies.

The authors hold that the better adjusted the child, the more likely he is to show clean-cut developmental sequences in his painting behavior, to be individualized, and to reflect his daily experiences in his drawings. Once one can determine the child's characteristic painting type, the deviations from this type become of great importance in depicting changes and modifications in the child's inner reactions to his experiences.

A careful examination of the research plan and the quantitative findings reveals a disappointingly large number of methodological weaknesses in this intriguing study. The authors themselves note that their conclusions may seem too pat, or too "far fetched." Possibly these too sharply delineated findings grow out of the subjectivity of much of the data. The fact that the authors constantly remind the reader that conclusions cannot be drawn from any one bit of evidence unless other sources confirm them is, on the surface, evidence of a search for internally consistently or reliable data (pp. 149–150). But when this principle of the "accumulation of evidence" is applied to relatively nonstructured evidence—such as anecdotal records, descriptive accounts of behavior, loosely con-

structed rating scales, and abstract paintings—the fertile mind of the observer can find more opportunity for discovering association than he might if the same data were reduced to quantitative scales and summarized in terms of correlation coefficients. The effect is that of judgments not taken independently—overlapping and spurious self-correlation. The very fact noted by the authors—that the characteristic pattern of an individual's drawings must be found over a long period—may be unwitting testimony that the observers needed time for their particular hypotheses concerning the child to "jell," after which a review of the data would produce ample support for the now-formulated conclusions.

The observers and teachers were asked to report anecdotes and ratings in terms of "changes and progress during the year." Here is a concrete illustration how the subjective valuations of the observer may operate to select data prior to the actual statistical assessment of interrelationships. The teacher's daily log was preferred to a time-sampling procedure, presumably because the behavior to be recorded was too complex and occurred over too long time intervals for time-sample analysis. The constant errors which may arise from such a procedure are at once apparent to any one acquainted with rating techniques.[1]

In all, only 31 lines of text (pp. 193, 194) are given to a formal discussion of the reliability and validity of the data. To get as true a picture as possible, the authors depended "upon repeated, many-directional fragments of evidence rather than upon any single well-validated and reliable measuring instrument. Our case for reliability and validity rests upon the consistency found between our various types of data and upon the coherency of the general picture toward which all these findings point" (p. 193).

Thus the interrelations found among the observations become the evidence of their own reliability and validity.

Certain more specifically questionable methodological procedures may be mentioned. The work of 149 different children was studied, 21 of these being followed for a second year. All the tables are based on 170 observations, showing that roughly 12 per cent of the observations are not independent. Adding this straight statistical source of intercorrelation to the subjective and summary nature of much of the data, it is not surprising that many associations significant at the 15-per-cent level do appear. Nor were the confidence levels established for this study explicitly stated. Comparison of tables

[1] Efforts to gain reliable and valid ratings through the pooling of information from several observers are not necessarily unrewarding, as the careful work of Harold E. Jones and his associates in the *California Adolescent Study* have shown.

and text shows that differences significant all the way from the 1-per-cent to approximately the 15-per-cent levels were, on occasion, included in the discussions of significant findings.

Moreover, the criteria for the selection of subgroups for comparison are not always clear. Since the numbers in the contrasted groups fall short of the total, one may assume that these groups were drawn from the extremes of a continuously distributed sample. Occasionally, one suspects that the characteristics being studied were treated rather as attributes than as variables (*e.g.*, p. 237). In such cases the criteria for segregating the subgroups are not revealed. It is generally desirable to make quite clear the basis on which the data are classified.

The authors note that children did not verbalize while in the early experience of painting; even later, they were likely to attach the name of whatever happened to catch their eye. Only gradually would they "spontaneously offer a free-association sort of verbalization" (p. 153). An alternative suggestion is available, and one that should not be overlooked in any experimental work with children—that the children learned what was expected of them and obligingly "played the same."

The authors' claim that the apparently irrelevant monologues that some children developed while painting were actually very revealing of emotional dynamisms at work, is unsubstantiated by statistical evidence. Indeed, careful checking between Volumes I and II shows that only a portion of the conclusions reached in Volume I are supported by data in Volume II. Another instance is the several times mentioned association between the use of brown, or the tendency to smear, and forced toilet training at home. The association was specifically noted for ten children (pp. 41–42). The scientifically trained reader will wish for data based on a survey of practices in all the homes, or measures applied to all members of the group.

Findings based on the individual case, and upon the clinically noted association of factors in selected cases, have the frequent and unfortunate results of appearing as generalizations. Certain associations may appear consistently in one child's work, and the significance for that child may correctly be assessed by the observer. If such an association is safely to be presented as a diagnostic characteristic for children in general, it should be supported by actuarial data, also. The authors' effort to work out intercomparisons within each child's data is commendable in itself. But the failure to work out group distributions and averages for various characteristics is a more serious omission than the authors consider. Lacking objective norms, the clinician evaluates the particular case against the

impressions left by his experience, and the proneness of the human intellect for a "hobby" or bias is only too well known.

The evidence in this study is attractively gotten together and interestingly, even fascinatingly, presented. Seldom are research reports as pleasurably read as this. However, this reviewer, although quite sympathetic with the "wholistic" approach and the basic assumptions of this study, considers the evidence incomplete for the findings presented. There is a danger that methodologically untrained readers, who will read Volume I and may overlook the tabular material in Volume II, will be led to accept unwarranted conclusions.

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PROBLEMS OF CHILD DELINQUENCY. By Maude A. Merrill. Boston: Houghton Mifflin Company, 1947. 403 p.

This study of delinquency presents the most recent sociological and psychological formulations (but avowedly not the last word) in this field. It is a report of a ten-year study, directed by a competent psychologist and staffed by field workers and statisticians, of 500 delinquents who appeared in a rural-county juvenile court in California, supplemented by a control group of 500 non-delinquents, matched for age, sex, and locality with the delinquents. A follow-up study after an interval of approximately five years attempts cautiously to evaluate the results of treatment and factors of success or failure.

There is a great amount of statistical material in which the Chi Square Method is used to determine significant differences between the two groups, but most of it is conveniently segregated in appendices, leaving the main text free for a highly interesting and readable discussion. Although the latest modes in terminology are used, the book is easily comprehensible to any intelligent person and is sufficiently profound and rich in interpretation to be of great value to workers in the field of delinquency.

Statistical findings are critically compared with those of other studies and are guardedly interpreted. They represent an advance in method and groundwork that will be fully appreciated only by research workers.

The recurrent theme of the treatise is the necessity of understanding the delinquent as an individual personality reacting within his frame of reference to the environmental pressures to which he is subjected. His pattern of behavior is a "mask" with which he confronts the world, or a "smoke screen" behind which he conceals his underlying insecurity. Illustrative case histories are excellent.

There is a wealth of critical evaluation of tests which will be of inestimable value to psychologists in this field. Social and economic factors are appraised as important only in relation to their meaning to the child. Family relationships are shown as sources both of security and of frustration, sometimes goading the child to exalt his self-esteem by fair means or foul. Delinquency offers him a way of life full of adventure, excitement, and sense of importance, with which no legitimate satisfactions can compete. However, delinquents and non-delinquents are shown to be more alike than different. It is their choice of aggressive reaction (acceptable or antisocial) that casts the die.

From the viewpoint of a child-guidance clinic there seems to be a lack of services of psychiatrists and of medical histories and consideration of physical defects. The psychopathic personality, the enigma of clinics, courts, training schools, and mental hospitals, is not touched upon.

The book is not only a "modern and scientifically based study," as Doctor Carmichael states in his introduction, but for all persons who work professionally with delinquents or who are interested in social welfare, it is a challenge to carry on this type of work until children shall no longer turn to the excitements of delinquency to satisfy the unmet needs of their lives.

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YOUTH IN DESPAIR. By Ralph S. Banay. New York: Coward McCann, 1948. 239 p.

This book is an attempt to inform the general public about juvenile delinquency in simple, non-technical language. Dr. Banay covers a wide range of topics through a total of some 220 pages. In addition, he gives a list of 209 bibliographical references, many of them from the daily papers.

For experienced, well-informed workers in the field, this book offers nothing new. For the general public, we doubt that it gives a well-balanced background of information. The reviewer gets the feeling that Dr. Banay has had too little direct experience with juvenile delinquents and has depended too much on popular concepts of what has been developed in this field.

Youth in Despair describes the persistence of earlier punitive concepts in the law and in methods of dealing with juvenile delinquents. The need for bringing law and practice into conformity with present scientific knowledge about juvenile delinquency is emphasized. Dr. Banay insists that punishment has always failed as a

deterrent to crime and that the desire to punish is based on instinctual sadistic drives and an irrational need to alleviate a sense of guilt because of the possession of prohibited desires.

Delinquent conduct is motivated by unsatisfied needs of the delinquent and is purposive in character, according to the author. He believes that the primary aspect of juvenile delinquency is medical rather than social or legal. We doubt that students in the field of juvenile delinquency would agree with him in this belief. Repeated studies have emphasized the small part that medical conditions and needs have played in juvenile delinquency.

In his discussion of the part that poverty plays in causing juvenile delinquency, Dr. Banay points out the close relationship between poverty and delinquency, slums and delinquency, and tuberculosis and delinquency, but the more puzzling fact that a relatively large number of children live under the same economic conditions and do not become delinquent is not mentioned.

The author agrees with previous writers on the importance of the family constellation in its influence on the child. He emphasizes the importance of the first five years in the life of the child and indicates that at the age of five or six, "the basic personality structure, the tastes and inclinations operative in the selection of friends and leisure-time activities, and the ultimate social adjustments are all strongly determined."

A review of the statistics regarding the race, religion, and sex of juvenile delinquents brings out the facts that boys show a preponderance of about four or five to one; that girls come into court largely for sex, uncontrollable behavior, and running away; that Negroes and children of the foreign-born furnish an excessive number of delinquents in proportion to their incidence in the population; that cultural conflicts, immigration, and other conditions that serve to upset family patterns influence the extent of delinquency.

In a chapter entitled *Mind and Body,* Dr. Banay discusses the psychopathic personality as a prolongation of infantile habits and patterns and indicates that this condition is frequently found in juvenile delinquents. The chronic delinquent, in our experience, is much more likely to belong to this group than the ordinary delinquent. The author also stresses real or imaginary, organic or functional, physical or mental handicaps and the part they play in the development of objectionable behavior. "It is not so much the extent of the defect that counts," he points out, "as the sensitiveness of the individual to reactions to that defect on the part of people within his environment."

Among the hopeful approaches to the problem of juvenile delinquency, according to Dr. Banay, are the diagnostic and treatment

clinics and probation. But only in a few isolated instances does he find a satisfactory development of these techniques and facilities. The importance of well-qualified staff for training schools and the use of mental-hygiene concepts in group and individual therapy is also stressed. Dr. Banay finds that most institutional programs fail to provide sufficient outlets of a constructive sort for delinquents.

A wise emphasis upon community-wide and concerted efforts of citizens and private and public agencies, and a flexibility of program strengthens the author's chapter on prevention, as do his brief reports on various preventive efforts throughout the country.

In understanding crime, modern concepts of human behavior must be used, according to Dr. Banay. These are:

1. All behavior is purposeful, although the individual may or may not be conscious of the purpose that impels the behavior.

2. A large part of what we do depends upon what we *feel*, not upon what we think; that is, behavior is more modified by the emotions than it is by reason.

3. Back of every psychological event, there are others from which it develops and which give it meaning, so that all the acts of an individual fall into a logical procession.

The author states that, crime is "a reaction to unendurable internal or external pressures suffered by the individual." His emphasis upon the omniscence of the psychiatrist in the field of juvenile delinquency may be questioned by members of other professions who have been active in this field. We immediately think of sociologists, social workers, psychologists, and others who have made not inconsiderable contributions to knowledge in this field.

In general, we believe that *Youth in Despair* contributes little to the body of knowledge in this field. It may have some merit in that it presents in popular form some of the contributions that have been made by workers in the field of juvenile delinquency, but we suspect that others have already done this better.

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JUVENILE DELINQUENCY: A CRITICAL ANNOTATED BIBLIOGRAPHY. Compiled by P. S. de Q. Cabot. New York: H. W. Wilson Company, 1946. 166 p.

There has long been a need for a bibliography in the special field of juvenile delinquency. This work is an excellent *terminus a quo*, not only for the special student, but for any student who has learned how to use an index. It covers the period from 1914, when material on the juvenile offender first began to appear, to 1944. It presents

the usual bibliographical data, with a brief paragraph summarizing the content of the work. Upwards of 900 books and articles from periodicals are noted, including not only American and English, but continental material as well. There is also a workable index by subjects. In his preface Dr. Cabot says: "The purpose of the volume is to assemble the hitherto scattered source material which has direct value for workers in this field of research. . . . Many lists of references that have previously appeared have not been annotated." The annotations seem entirely adequate; the reviewer, some of whose material is included, is satisfied with what appears. Which is praise from Sir Hubert!

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THE SECOND FORTY YEARS. By Edward J. Stieglitz, M.D. Philadelphia: J. B. Lippincott Company, 1946. 317 p.

This book, written in non-technical language for lay readers, is a valuable contribution to the literature on the medical, psychological, and socio-economic problems of aging. The author states that the purpose of the book is "to offer guidance toward wiser ways of living in the hope that those who are approaching or have passed the meridian [the age of forty] may profit." It is the reviewer's opinion that Dr. Stieglitz has succeeded very well in achieving this purpose.

In the first four chapters the author discusses the general meaning and significance of aging, as well as the biology and hazards of senescence. He presents the fact that physiologic age is not the same as chronologic age, and stresses the individual's need to mature emotionally as well as physically in order to make the best adjustment in later life.

In succeeding chapters, devoted to discussing life with a handicapped heart or with high blood pressure, the importance of the early detection of these disorders by means of periodic physical examinations is emphasized. Instead of going into details of treatment, the author wisely urges the individual with such a condition to coöperate fully with his personal physician. This approach is sound from the mental-hygiene standpoint, as the author thereby avoids engendering in his readers apprehension or hypochondriacal concern.

A chapter entitled, *Sex and Age,* presents the climacteric as a phase of normal maturation during which 95 per cent of people are free from distress. The importance of emotional adjustment during this period of life is stressed, as well as the fact that physicians with improved endocrine preparations and psychotherapy are now well equipped to help those in whom there are indications for such measures.

The mental hygiene of later years and the personality disorders of this period are discussed in a clear, as well as a reassuring, manner.

In presenting the importance of a wise use of leisure by the elderly, the author gives detailed practical suggestions as to the use of hobbies and regulated exercise in overcoming boredom and in achieving creative activity.

Under the title, *An Aging People,* Dr. Stieglitz demonstrates his deep appreciation and knowledge of the complex socio-economic problems brought about by the increasing number of older people in our population.

In a final chapter, *Constructive Medicine,* the author urges the use of a periodic health inventory in which the physician would make a thorough study of the patient's lowered reserve capacities, the object being to obtain a more nearly optimum level of health for the individual throughout his life span.

This book is clearly written, and the illustrations contribute to an understanding of the text. A valuable list of collateral readings is appended, and the brief index at the end of the book makes the content readily accessible. The book should be of great value to all who are interested in learning about the physical and psychological changes that occur with aging, and who desire to inform themselves as to what can be done to adjust to these changes in order to lead happy and effective lives during the second forty years.

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MENTAL MISCHIEF AND EMOTIONAL CONFLICTS: PSYCHIATRY AND PSYCHOLOGY IN PLAIN ENGLISH. By William S. Sadler, M.D. St. Louis: The C. V. Mosby Company, 1947. 396 p.

In his preface, the author of this book states that the descriptions and teachings contained therein represent over forty years of professional experience with the mental, emotional, nervous, and personality problems of distraught and fear-ridden human beings.

The book is written on a popular level, and is intended to serve as a mental-hygiene guide to persons who suffer from functional nervous disorders, or in whose families there are victims of emotional conflict. The public is becoming increasingly aware of the help that psychiatry can give in dealing with many domestic and social problems, and there is a great need for subject matter that will clarify the many misconceptions in this field.

There are 34 chapters in the book, with such titles as: *Nervous and Emotional Disorders, Mischief-Making Complexes, Emotional*

Suppression and Rationalization, Wishful Thinking and Sublimation, Inadequacy Feelings, The Conscience Complex, Habit Pains and Hypochondria, Manipulating the Reality Feeling, Hypnotism and Telepathy, Mental Hygiene—Psychotherapy, and *A Philosophy of Life.* These headings represent considerable deviation from accepted psychiatric terminology and nomenclature.

The author discusses a diversity of problems relating to mental hygiene. His language is simple, direct, and in some instances whimsical. He endeavors to be non-technical, and in so doing, there is danger of being unscientific.

The text is replete with case studies that illustrate the rules of mental hygiene. Some of them are naïve in their presentation, and not fully in accord with present-day psychiatric theories of therapy. Yet it is helpful to have the material outlined as Dr. Sadler has outlined it. The neuroses are characterized by: (1) deficient attempts at adaptation to life; (2) projection of one's inferiority qualities on to others; (3) identification of one's self with the superior qualities of others; (4) utilization of neuroticism as an everpresent alibi for dodging difficult or unpleasant life situations; (5) tendency toward regression to lower levels of thinking and acting; (6) absence of goal striving—failure to acquire an adequate philosophy of life; (7) establishment of compulsion rituals for the purpose of reducing nervous tension; and (8) resort to hysteric symbolisms for the purpose of compensating repressed emotions. This system of outlining is characteristic of the author's work.

In his chapter on nervous and emotional disorders, Dr. Sadler states:

> "Nerves are man's friend, not his enemy. The subconscious, whose machinations cause so much trouble in human experience, is, after all, when properly disciplined and sufficiently trained, a beneficent servant. It is only when these mechanisms escape from intelligent control or become maladjusted that they trouble and harass us."

Dr. Sadler refers to the subconscious mind as one's other self, and says that at any given moment, but little of our mental lives and accumulated experiences are encompassed by our immediate consciousness. Most of our psychic lives, for the time being at least, are buried in the subconscious realms.

In the section on association of ideas, he deals with auto-suggestion, and then becomes involved in a discussion of mediums and clairvoyants. He states that association of ideas may be termed the psychic clearing house, because the great majority of human concepts and mental images pass that way en route to the realms of higher thought activity. "It is not too fantastic to imagine that thought wrecks and other *psychic catastrophes* may occur as the

result of misthrowing switches and misreading signals in this important and mysterious mental realm." In the author's efforts to simplify the material, the basic meaning is sometimes lost.

Mental hygiene and psychotherapy are treated together, and Dr. Sadler talks about employing the three direct methods of complex hunting—crystal gazing, automatic writing, and hypnosis. These subjects should have been discussed in technical terminology; their presentation to a lay public in simplified terms is likely to cause misunderstanding.

The author should have elaborated on the techniques of catharsis, the interpretation of conflict material, desensitization, and suggestion, which are several of the accepted methods of psychotherapy.

There is a separate chapter on hypnotism and telepathy, with references to shell hearing, trances, spiritualistic mediums, and communications with the dead. Much of this material would better have been omitted; it borders on mysticism and has no place in modern psychiatry.

The various psychoses are discussed briefly. The treatment of dementia præcox is dealt with in several lines as follows: "Medicinal and electric-shock treatment, as well as the deep-sleep therapy, have been effective in a large number of cases, especially in the more acute and catatonic forms. Insulin shock is used with good results in certain types."

No reference is made to the use of occupational therapy, hydrotherapy, or the other therapies that are so useful and important in the rehabilitation of the patient. Religious therapy is discussed in the chapter on a philosophy of life, and here the author makes several real contributions. I cannot agree, however, that prayer is the highest and truest form of psychotherapy.

I have criticized this book perhaps harshly, but I have felt justified in so doing because it is not modern in its discussion of mental hygiene and may be confusing and misleading to the layman.

LEO MALETZ.

Lynn, Massachusetts.

FATIGUE AND IMPAIRMENT IN MAN. By S. Howard Bartley and Eloise Chute. New York: McGraw-Hill Book Company, 1947. 429 p.

This exceedingly interesting volume from the Dartmouth Eye Institute is an attempt to present the every-day observations of fatigue and impairment in man and the numerous efforts at special investigation of these topics by whatever method, and finally to formulate the whole problem in terms of reasonable questions to be asked and indications for needed research. Some idea of the extent of the problem and the authors' approach to it may be gained from

the fact that they present historical material on various views concerning fatigue and allied concepts, and a digest of research studies on its electrophysiology, its relation to anoxia and other limiting conditions, lack of blood sugar, temperature extremes and salt lack, metabolism and nutrition, hours and conditions of work, drug action, and so on. There are excellent digest chapters on sleep and other periodicities, long-term changes in the individual, mental fatigue, personal factors in the work situation, conflict and frustration, chronic fatigue and related syndromes, and—as might be expected—visual-performance and visual-fatigue studies.

The authors come quite properly to the conclusion that fatigue and impairment are not one and the same thing; that our basic knowledge of fatigue derives from common-sense observations known to us all, for which we have not as yet found any suitable methods of measurement or refinement of observation; furthermore, that special studies dealing with special systems—be they endocrine, metabolic, electrodermal, or what not—are only minute and isolated points in a pattern that is to be understood finally only in terms of the subject organization of the individual. Fatigue is not to be expressed in quantitative units. They suggest the following points as important for future work:

1. Definitions are required as a basis for fruitful experimentation.
2. Concepts must form a unitary system with regard to the phenomena studied.
3. Phenomena change with the passage of time and this fact must be taken into account in fatigue experimentation.
4. In studies of human activity, the individual must be taken as reference.
5. The full set of dynamic factors operating in the individual must be taken into account.
6. Experiment should be as much a part of "real life" to the subject as possible.

This is probably the best book of its kind. It deals with every known aspect of the topic and effectively states the difficulties of study and of experimental measurement. As a statement of the present situation in this field, it is invaluable.

WENDELL MUNCIE.

Baltimore, Maryland.

SO YOU WANT TO HELP PEOPLE. By Rudolph M. Wittenberg. New York: Association Press, 1947. 174 p.

So You Want to Help People is a challenging title for a book addressed to the non-professional who is engaged in work with people for educational purposes. It is obvious that this is Dr. Wittenberg's

response to a need discovered through actual experience in trying to improve the skills and understanding of volunteers in settlements, Scout programs, churches, and "Y's." The title emphasizes the fact that more than a kind heart and good intentions is required of one who would serve through education.

The book itself, however, is a disappointment. The author demonstrates one of our major difficulties in the field of guidance and group work: intellectual acquisition in the absence of emotional comprehension. Repeatedly, Dr. Wittenberg expresses adequately what he calls "principles of mental hygiene," and follows them with illustrations that completely contradict the principles so well enunciated. An example is his description (pp. 40–42) of the basketball coach who supposedly accepts the members of his "groups" (actually teams) at their own values "rather than in comparison with 'absolute' performance."

Several unfortunate concomitants follow from this initial "split": (1) education is confused with psychotherapy—*e.g.* (pp. 44–46), use of drama to correct emotional disturbance; (2) manipulation of "clients" is mistaken for relationship with group—*e.g.* (pp. 147–150), protecting children from peers; (3) adult domination is interpreted as group discipline; and (4) adult-imposed activities are confused with group-generated programs based on adult flexibility and guidance. A continued emphasis throughout the book is the pitting of adult wit and alertness against inevitable attacks from the children who are to be "helped to help themselves."

The net result is a series of high-sounding principles without substantial evidence of an integrating process of education.

Examples of contradiction between "mental hygiene" principles and the practices approved by the author could be multiplied. For instance, in the chapter on "religious education," the author does not challenge the use of traditional materials or the appropriateness of the setting in which education is supposed to take place. It is apparently assumed that the adult has a right to expect compliance and decorum simply because that is the kind of situation in which such behavior is expected. Therefore, "discipline" may be *enforced* (p. 157).

Chapter V, *Boy Meets Girl*, is the most constructive in the book. The language is simple, the attitude relaxed, and the content helpful, because it remains on the level of information about the usual and natural, without delving too deeply into pathology. The leader-child relationships illustrated are warm, accepting, and sympathetic without morbidity or sentimentality. There is an open directness in approach to the subject. The chapter is characterized by inclusive thinking which serves to eliminate the usual notion of the separateness

of things sexual. The author expresses the spirit of his original intentions in writing the book when he says, "No one can truly be protected from danger over any length of time, but he can be made so secure that he can protect himself."

Underlying the unfortunate aspects of this book is a common error in the field of mental hygiene to-day—namely, that the authors and lecturers, who are themselves well versed in the "tools of the trade," do not apply the "principles" to their readers and hearers. Lacking orientation in psychopathology, and usually acclimated to an authoritarian, competitive atmosphere, the layman's fears are aroused by descriptions of pathological behavior and dynamics, and his rigidity is reinforced by sanctions for adult imposition of programs. Even in writing or speaking on this keystone subject, "So You Want to Help People," it is important to keep before us that "the leader's job is not to ask them what they would like to do, but rather to help them relax enough to be able to express themselves," (p. 49).

Somehow we must discover ways of enabling authors and lecturers to relax so that they can express themselves more consistently.

CHARLES G. MCCORMICK.

Vassar College.

SUGGESTIVE THERAPEUTICS—A TREATISE ON THE NATURE AND USES OF HYPNOTISM. By H. Bernheim, M.D. Translated from the second and revised French edition by Christian H. Herter, M.D. New York: London Book Company, 1947. 420 p.

This reprint of Bernheim's classic work on hypnotism is a most welcome addition to the library of the student of hypnosis. The original work appeared in 1886 and its English translation in 1889. Having been out of print for many years, both the original and its translation have practically become collector's items. The present reprint is justified not only because of this, but also because the book, in spite of its age, still has much to contribute to our present-day knowledge of hypnosis as a medical science. *Suggestive Therapeutics* will thus prove itself to be more than a volume of historical interest, and the astuteness of Bernheim's observations as recorded in the book will enable the reader to mine from it much significant material.

Many of Bernheim's discoveries and conclusions are as valid to-day as they were when he first described them. Bernheim recognized hypnosis as a purely psychic phenomenon allied to, but distinct from, sleep. He believed hypnosis to be a state of enhanced suggestibility that enabled the operator to implant in the mind of the subject injunctions which the latter accepted much more readily than in the waking state. He alleged that the same phenomena could be produced in waking life in a subject who could not be hypnotized by

simple affirmation as in one who could be hypnotized. Bernheim's descriptions of the stages of hypnosis and the various phenomena observed in the trance have been improved upon but little by more modern workers in the field.

Authoritative suggestion, which is the basic therapeutic device utilized by Bernheim, is, of course, immensely overrated as a therapeutic agent. This limitation must be judged in the historical context in which the book was written, since the dynamic discoveries in psychopathology that Freud introduced had not yet been brought to light. It is quite apparent in reading the book that the important function of unconscious conflict in determining symptoms was hardly recognized by Bernheim. It is consequently not surprising that the therapeutic approaches outlined by him are so strongly directive and authoritarian, employing symptom removal by authoritative suggestion as well as a directive persuasive approach.

The book includes a description of a variety of emotional problems that Bernheim claims to have aided through the use of hypnosis. Included among these are "Organic Affections of the Nervous System, Hysterical Affections, Neuropathic Affections, Neuroses, Dynamic Paresis and Paralysis, Gastro-Intestinal Affections, Various Painful Affections, Rheumatic Troubles, Neuralgias, and Menstrual Troubles."

Suggestive Therapeutics is a fascinating document, replete with interesting case material which the reader will find most absorbing. The presentation is excellent and the style lucid. The book is highly recommended; indeed, it is an indispensable volume for the psychiatric worker who is interested in hypnotherapy.

LEWIS R. WOLBERG.

New York City.

BRINGING UP CHILDREN. By Dorry Metcalf. New York: Pilot Press, 1947. 120 p.

This addition to the abundant and rapidly growing stock of child-rearing literature for parents is a slender volume of 120 pages. Its four chapters bear the headings, *Attitude, Infant, Two-Year Old,* and *Child.* In simple, conversational language, which sometimes takes on a colloquial English flavor, the author attempts to give the psychological framework of child care in the early years.

The opening chapter has a straightforward and natural approach to the importance of consistency and balance in parents' attitudes toward their children. Particularly good are the points made about individual differences, the many-sidedness of growth, and ways in which to meet the child's increasing need for independence.

However, the book tends to cover a wide range of items from the physical and emotional areas in a rather thin and loosely organized

style. Also, the frequent use of such didactic expressions as "we should" and "we should not" is too pedagogical for comfort. *Bringing Up Children* has a place in the supplementary reading of parents. It is not a substitute for such comprehensive books as Spock's *Baby and Child Care* or *Children in the Family,* by Powdermaker and Grimes. But it does give the layman a valuable, simplified interpretation of psychological material that all too frequently gets lost in the obscurity of its technical labels.

EVELYN D. ADLERBLUM.
Public School Mental Hygiene Project, New York City.

LOVE WITHOUT FEAR. By Eustace Chesser, M.D. New York: Roy Publishers, 1947. 307 p.

This book is both a plea and a plan for better understanding of sex technique as the basis for increased happiness in marriage. It compares favorably with other books of its kind. It is written with exceptional clarity and has enjoyed considerable popularity in England, where it was first published.

The volume has many virtues and, prior to January, 1948, this reviewer would have looked upon it with favor. But that was before the appearance of Kinsey's *Sexual Behavior in the Human Male.* The Kinsey study raises a serious question as to the value of "the art of love" for sexual satisfaction. Specifically, the Kinsey data show that preoccupation with techniques of sexual intercourse is a middle-class phenomenon in the United States which writers on the subject, since they are themselves members of the middle class, unwittingly universalize; whereas in truth the lower classes regard love-making preliminary to coitus with considerable contempt. Yet Kinsey reports that a larger percentage of lower-class than of middle-class women reach an orgasm.

It is plain that, lacking scientific studies of human sex behavior, we have relied on the judgment of "experts"—sexologists and psychiatrists—whose experience has been limited to selected and unrepresentative cases.

There is much of value for the discriminating reader in *Love without Fear,* but for a valid, realistic, and adequate understanding of the rôle of sex in human behavior, we shall have to wait until we have more studies of the scope and scientific order of the Kinsey report.

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NOTES AND COMMENTS

Federal Grants under National Mental Health Act

The award of federal grants for the training of mental-health personnel and for research in the field of mental health, under the National Mental Health Act, for the fiscal year, 1949, has recently been announced.

The mental-health program, authorized by Congress in 1946, received an appropriation of $9,028,000 for the fiscal year, 1949. This is to finance a threefold program of research on mental illness, development of local mental-health facilities, and training of mental-health personnel, in addition to mental-health activities within the Public Health Service. Two million dollars was appropriated for training and research grants and fellowships. Approximately $1,430,000 will be spent for training grants, including training stipends for graduate students in the field of mental health; $470,000 for research grants; and $100,000 for research fellowships.

In addition, Congress has authorized $2,300,000 to support grants for research and training in the years subsequent to 1949. For grants-in-aid to states, Congress appropriated $3,550,000. These funds will be allocated to the states on the basis of population, financial need, and extent of the mental-health problem. The remaining funds will be spent for the operation of the two Public Health Service hospitals at Lexington, Kentucky, and Fort Worth, Texas; training and research other than grants and fellowships; demonstrations; consultative services; and administration of the Mental Hygiene Division, Public Health Service.

The grants recently announced go to universities, hospitals, and clinics to support their training programs and to provide training stipends in the fields of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing, and to support research in the field of mental health. The grants were recommended by the National Advisory Mental Health Council, a body of experts in the mental-health field, and were approved by the Surgeon General of the Public Health Service.

The council considered applications for 205 training grants and 1,099 training stipends, of which it recommended approval of 143 training grants and 561 stipends. With the funds appropriated by Congress for 1949, it was possible to award 86 training grants and 264 training stipends.

Improved Methods Enable Veterans Administration to Keep Down Hospital Load

Improved techniques in the care of mentally ill veterans are enabling the Veterans Administration, for the first time in many years, to discharge about as many patients as it admits to its neuropsychiatric hospitals.

Generally, admissions and requests for care exceed the number of patients discharged. However, during a recent ten-month period (July, 1947, through April, 1948) 1,060 more neuropsychiatric patients were discharged from hospitals than were admitted. During this period, 51,210 patients were admitted for care and 52,270 were discharged as improved or cured.

For the twenty-two-month period from July, 1946, through April, 1948, 107,579 patients were admitted to hospitals for treatment, as compared with 106,694 discharges—that is, there were only 885 more admissions than discharges.

This is an indication that improved methods of care and the establishment of more mental-hygiene clinics for out-patient treatment have enabled the Veterans Administration to keep its hospital load of mentally ill from increasing substantially.

The following figures show the rate of admissions and discharges of neuropsychiatric patients from Veterans Administration hospitals since July, 1946:

Period	*Admissions*	*Discharges*
July–December, 1946	26,528	25,296
January–June, 1947	29,841	29,128
July, 1947–April, 1948	51,210	52,270
Total	107,579	106,694

Improved or new techniques and new policies that permit more effective and more rapid treatment of mental patients include:

1. The establishment of neuropsychiatric units in general-medical hospitals to permit intensive early treatment of acute psychotic and other psychiatric patients.
2. The establishment of general-medical and surgical sections in neuropsychiatric hospitals, along with the organization of acute intensive treatment, and continued-treatment services for the acutely ill and long-term patient.
3. The use of electric-shock and insulin-shock therapy.
4. The performance of prefrontal leucotomies on selected groups of patients.
5. Increased use of psychotherapy, both individual and group.
6. Extensive educational programs, residency training, and affiliation with top medical schools in all the neuropsychiatric specialties.

7. The extension of mental-hygiene clinics to treat eligible veterans before they become ill enough to be hospital patients.

8. The introduction of the "team technique" in the mental-hygiene clinics. Each team—consisting of a psychiatrist, a clinical psychologist, and two psychiatric social workers—carries a full case load of patients, greatly speeding treatment and preventing many veterans from becoming patients in mental hospitals by early effective treatment of their illnesses.

9. Testing of the "team technique" in rural areas in the hope of bringing "traveling mental-hygiene clinics" to veterans outside metropolitan areas.

10. Reorganization of the neurology service and the establishment of neurological diagnostic and treatment centers to which patients from areas lacking competent neurological staffs can be referred.

11. The establishment of a clinical-psychology program which has become a vital part of the diagnostic and treatment teams in hospitals and clinics. Through the interest of psychologists, neurologists, and psychiatrists, many research studies into little-known diseases and injuries have been undertaken.

12. Widespread utilization of volunteer workers in mental hospitals and the development of a program of public education regarding mental illnesses.

13. Participation of Veterans Administration professional people in community and professional activities outside the hospitals.

14. The establishment of research programs into the causes of war neuroses, epilepsy, schizophrenia, and other ailments. Group psychotherapy, shock therapy, and other methods of cure also are subjects on the research programs.

15. The establishment of special laboratories for studies in pathology and psychosomatic disorders.

16. More extensive use of narco-synthesis and hypnosis.

17. Intensive medical rehabilitation for chronic patients, including those suffering from the diseases of old age. A current survey reveals that despite improved rates of discharges from hospitals, 74 per cent of all the patients now in neuropsychiatric hospitals have been there for over a year and 55 per cent of the neuropsychiatric-hospital population have been there over three years. Concerted efforts are being made to rehabilitate this group so that they may leave the hospital or be better able to care for themselves within the hospital. Plans to effect these goals include intensive application of physical-medical rehabilitation procedures for all chronic patients, including the aged; wide extension of trial visits, either in the patient's own home or in other suitable supervised home; and the

establishment of hospital clinics to assist trial-visit patients in remaining out of the hospital.

18. The inauguration of a physical-medicine rehabilitation program, including aural rehabilitation and speech correction, educational therapy, manual-arts therapy, and physical therapy, to assist in the physical and mental recovery of all veteran patients.

Mental-Hygiene Research Fellowships Offered by Public Health Service

In order to promote the interest of competent research workers in the field of mental health, the United States Public Health Service is offering a limited number of mental-hygiene research fellowships for graduate work in medical and related sciences. These fellowships are open to psychiatrists, psychologists, social workers, anthropologists, sociologists, and any other persons interested in research in the field of mental health who have the proper qualifications.

A pre-doctorate research fellowship is available to qualified applicants. For those with a bachelor's degree, the stipend is $1,200 a year, $1,600 a year for those with dependents. For applicants with a master's degree or its equivalent in graduate work, the stipend is $1,600, $2,000 for those with dependents. Tuition for courses taken in connection with the fellowship will also be paid. These fellowships are also granted to medical students who have completed one or two years of their medical course and who wish to spend one, two, or three additional years in a basic science relating to mental health before completing their studies toward the M.D. degree.

A post-doctorate research fellowship is awarded to qualified individuals holding a doctor's degree in medical or related fields. This fellowship carries a stipend of $3,000 per year for doctors without dependents and $3,600 per year for doctors with dependents. Post-doctorate fellowships which are renewed are increased $300 over the previous year. Tuition fees are not provided with this fellowship.

A special research fellowship is awarded to applicants who qualify for a post-doctorate fellowship and in addition have demonstrated outstanding ability or who possess specialized training for a specific problem. This fellowship does not carry a set stipend, the amount being determined in the individual case.

Applicants are required to file a statement outlining the investigation upon which they will work.

Requests for application forms and additional information on research fellowships should be addressed to the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Maryland.

Veterans Administration Offers Residency Training in Psychiatry and Neurology

The Veterans Administration has immediate openings for at least one hundred young doctors interested in taking residency training in psychiatry or neurology or both, according to a recent announcement by Dr. Paul B. Magnuson, chief medical director.

The Veterans Administration hospitals in which these residencies are offered are situated in almost every section of the country. All are under the supervision of the deans' committees, mostly composed of members of university faculties of Class "A" medical schools.

Applicants for residency training in these fields must be citizens of the United States, and graduates of a school of medicine approved by the Veterans Administration and the Council on Medical Education and Hospitals of the American Medical Association, and they must have completed an interneship acceptable to the Veterans Administration.

In general, these residencies cover a three-year program of specialty training, although one- and two-year programs also are available at most of the hospitals.

Junior or first-year residents must have completed a satisfactory interneship and be considered ready for specialization. Intermediate or second-year residents must have the qualifications of a junior resident and the equivalent of one year's training in the specialty. Senior residents must have the qualifications of a junior resident and two years' training in the specialty.

Interested doctors may obtain information and application forms regarding the residencies by writing the Chief Medical Directors, Veterans Administration, Washington 25, D. C.

Residency selection and residency grades for the individual are recommended by the dean's committee supervising the program at the Veterans Administration hospital in which the applicant desires to train.

Children's Bureau Organizes a Clearing House for Research in Child Life

The organization of a clearing house of current research in child life got a start last August with the appointment of Dr. Clara E. Councell to the staff of the Children's Bureau, Washington, D. C. Dr. Councell will be responsible for setting up and directing the clearing house as an aid to professional people in the exchange of information on research.

In announcing the appointment of Dr. Councell, Dr. Martha M. Eliot, associate chief of the bureau, stated that the clearing house

is being developed in response to recommendations of professional organizations and advisory committees primarily to aid research workers and organizations in keeping abreast with research in progress.

"Research in the social, cultural, psychological, and physical aspects of child growth and development, in cultural patterns affecting family life, and in the development of health and welfare services for children, is now going on in many universities, schools, and centers throughout the country," Dr. Eliot said, "but until now there has been no one place where a research worker can find out what other people are doing in the same field or in fields related to this work."

Many projects require months, and even years, for completion. Thus it is some time before the published findings become generally available. Meantime, work on one project might be modified and made more effective if researchers knew about others going on at the same time in related fields. The Children's Bureau clearing house, it is hoped, will provide a systematic way of keeping professional research workers informed on current projects as they are planned and as they develop. It should also tend to stimulate more research in child life, particularly in some specialized fields in which it is lagging or lacking altogether.

Dr. Councell comes to the bureau from the Institute of Inter-American Affairs, an agency of the Department of State, where she assisted in keeping professional people in Latin America informed of current research in medicine and public health in the United States. Before that she held important positions in the United States Public Health Service, primarily in the field of public-health methods.

Dr. Councell is a graduate of Goucher College, Baltimore, where she majored in chemistry. Later she received her master's degree, in statistics, from Johns Hopkins University, and more recently her doctorate in public health from Yale University. She has taught at both Goucher and Yale. Dr. Councell is a member of the American Public Health Association, the American Statistical Association, the American Biometrics Association, and the Population Association of America. This year she is serving as secretary of the Vital Statistics Section of the Public Health Association.

Advisory Council Appointed by New York State Commissioner of Mental Hygiene

With the approval of Governor Dewey, Dr. Frederick MacCurdy, New York State Commissioner of Mental Hygiene, has appointed an advisory council to his department. This advisory council, representing various aspects of community activity in the fields of psychiatry, social welfare, general medicine, and public health, was

appointed to advise the department of mental hygiene in the expansion of New York State's mental-health program to deal with the ever-increasing community needs.

The advisory council will meet monthly with the commissioner of mental hygiene. Dr. Howard W. Potter, professor of psychiatry at the Long Island Medical College, New York City, was named as chairman of the council. Other members of the council are as follows: Dr. Edward A. Sharp, psychiatrist in private practice and consulting neurologist; Dr. S. Bernard Wortis, consultant in mental hygiene to the United States Public Health Service and professor of psychiatry at the New York University College of Medicine, who represents the New York State Medical Society; Dr. J. Lawrence Pool, neurosurgeon, Neurological Institute, New York City; Dr. L. Whittington Gorham, formerly physician in chief at Albany Hospital and professor of medicine at Albany Medical College; Marian F. McBee, psychiatric social worker and Executive Secretary of the New York Committee on Mental Hygiene; Ralph King, President of the New York State County Welfare Association; Henry J. A. Collins, Judge of the Children's Court in Nassau County.

Among the projects in which the council will aid the commissioner and his staff is a more comprehensive educational program to promote the mental health of children. Facilities for child-guidance and mental-health clinics will be studied with a view toward amplifying this essential public service. Community requests for assistance will be studied and evaluated by the council in terms of local needs and the requirements of the state as a whole.

The council will also assist the department in coöperation with hospital groups to develop plans for greater provision for the care of mentally ill patients in general hospitals. The department hopes, the commissioner indicated, to develop also, with the assistance of the advisory council and the state medical society, extensive programs of mental care through coöperation with the medical profession generally. They likewise hope to promote a better understanding of the basic philosophies and practical needs of an effective state-wide mental-hygiene program.

American Occupational Therapy Association Holds Thirty-first Annual Convention

More than 500 leaders in the field of occupational therapy, representing every section of the United States, participated in the Thirty-first Annual Convention of the American Occupational Therapy Association at the Hotel Pennsylvania, in New York City, September 7 to 11. The association has approximately 3,000 members professionally engaged in rehabilitation activities.

Among the outstanding speakers who presented papers were: Mr. Holland Hudson, Director of the Rehabilitation Service, National Tuberculosis Association; Dr. Luther Woodward, Field Consultant to The National Committee for Mental Hygiene; Dr. Leland E. Hinsie, Assistant Director, New York State Psychiatric Institute; and Mr. S. R. Slavson, Director of Group Therapy, Jewish Board of Guardians, New York City.

On September 10 and 11, a teaching institute presented recent developments and techniques in the treatment of neuropsychiatric conditions. Various trips to hospitals and other institutions in New York City and surrounding areas, were arranged on September 9 and 10 for those attending the convention.

Conference of the American Group Therapy Association

The Sixth Annual Conference of the American Group Therapy Association will be held Friday and Saturday, January 21 and 22, at the Einhorn Auditorium, Lenox Hill Hospital, New York. One session of the conference will be devoted to an analysis of the nature of leadership in ordinary groups and therapy groups. A number of sociologists and psychotherapists have been invited to participate in this symposium. Dr. S. H. Foulkes, of London, England, has consented to come to the United States to deliver one of the main papers in this symposium.

The topic of another session is "Contemporary Research in Group Psychotherapy." Papers dealing with "Basic Dynamics in Analytic Group Psychotherapy," "Regression in Activity Group Therapy," and "Resistance in Analytic Group Psychotherapy," will be presented. Among the participants will be Hyman Spotnitz, S. R. Slavson, Betty Gabriel, and Harriet Montague.

Three round tables on specific aspects of group therapy are also being planned.

Preceding the main conference, an all-day conference has been arranged for Friday, January 21, for staffs of mental hospitals exclusively, to explore the specific problems in group therapy in such institutions.

The association's address is 228 East 19th Street, New York 3, New York.

Annual Convention of the National Society for Crippled Children and Adults

The Twenty-eighth Annual Convention of the National Society for Crippled Children and Adults will be held at the LaSalle Hotel, Chicago, November 15–17.

Many outstanding speakers in the fields of medicine, health, and

education will be on hand to present facts on progress in work with the handicapped during the past year, according to Lawrence J. Linck, executive director.

The convention will be attended by physicians, therapists, educators, workers with the handicapped, and representatives of the national society's more than 2,000 state and local units throughout the United States, Canada, Alaska, and Hawaii.

Scholarships for specialized training in cerebral palsy have recently been awarded by the national society to eight physicians, surgeons, and therapists. This is the first national scholarship program established to meet the challenge of a crippling condition that disables some half-million Americans.

The scholarships were made possible under the first of six $5,000 yearly grants from Alpha Chi Omega, national women's sorority, which has adopted help to the cerebral palsied as its major national altruistic project. The scholarships will help meet the acute shortage of specialists trained in cerebral palsy.

The scholarships will cover study at the Children's Rehabilitation Institute, Cockeysville, Maryland, under the supervision of the institute's director, Dr. Winthrop M. Phelps. Dr. Phelps, internationally recognized authority on cerebral palsy, is also President of the American Academy for Cerebral Palsy and chairman of the national society's medical advisory council on cerebral palsy.

The national society, whose services to all types of handicapped persons is made possible by the annual sale of Easter Seals, is the only agency conducting a nation-wide program on behalf of the cerebral palsied.

1949 Reading Clinic Institute

The Sixth Annual Reading Clinic Institute at Temple University has been announced for the week of January 31, 1949.

A three-year program of institutes has been planned in coöperation with boards of education. For 1949 the emphasis will be on the semantic, or meaning, approach to reading. Activities of the preceding institutes will be summarized in terms of the three approaches used: differentiated reading instruction, the integrated language-arts approach, and reading needs in content areas. Semantic analysis techniques will be described and demonstrated in relation to developmental, corrective, and remedial reading.

Half-day sessions have been organized to evaluate local and state reading programs. Special sessions will be held on reading needs at the elementary, secondary, and college levels. This permits boards of education to have existing programs appraised and projected

programs evaluated. Delegates should write for specific instructions on the preparation of their reports.

The emphasis will be on reading needs in classroom situations. Lectures and demonstrations will be given on the semantic approach to reading. Special research seminars have been organized to translate research into schoolroom practices. Child-study groups will be under the direction of the Reading Analysis Division staff. Differentiated program sequences have been developed for: (1) elementary teachers, (2) secondary and college teachers, (3) school psychologists and special classroom teachers, (4) supervisors and administrators, and (5) vision specialists.

In addition to an unusually fine selection of exhibits on books, supplies, and equipment, a special exhibit of school work has been planned.

All advance registrations must be verified prior to the date of the institute. For a copy of the program and other institute information, write: The Reading Clinic Secretary, Temple University, Philadelphia 22, Pennsylvania.

Sociometric Institute Offers Courses in Marriage and Family Relations

The Sociometric Institute of New York City has announced the opening of an educational and research center in marriage and family relations. The center is offering courses for engaged couples who wish to prepare sensibly for wedlock; married couples who wish to improve their relationships; research specialists in kindred areas of knowledge; social workers, nurses, counselors, and others who seek the improvement of family living and the strengthening of the family structure.

In a progressive sequence of group studies, special attention will be directed, through active methods such as psychodrama, sociodrama, and sociometry, to such subjects as romance, courtship and mate selection, marriage and the problems of living together, preparation for parenthood, and so on.

Arrangements may be made for special sessions for clubs, high-school and college classes, parent-teacher organizations, church groups, and the like. Information as to sessions and fees may be obtained from the Sociometric Institute, 101 Park Avenue, New York 17, N. Y.

American Association on Mental Deficiency Sets Up Central Office

The American Association on Mental Deficiency has set up a central administrative office at Washington Crossing, New Jersey. The purpose shall be to coördinate and consolidate the activities

and thought in the association's over-all program and to stimulate and integrate the work of the seventy-three-year-old organization and the new international organization.

Kansas to Have Largest Speech-Correction Institute

The nation's largest speech-correction center, with 41 buildings covering 40 acres of ground, is to be built at Wichita, Kansas, at a cost of $1,557,823, according to a recent announcement by Dr. Martin F. Palmer, Director of the Institute of Logopedics, and President of the American Speech and Hearing Association.

The model speech-correction center, unlike any other in the world, is being financed by gifts to the institute and by a loan from the Equitable Life Assurance Society, of New York, the loan being guaranteed under title 608 of the Federal Housing Act. It is expected that the plant will be in operation within the next eighteen months.

Planned to provide housing, training, and vocational therapy annually for 400 children, handicapped by all types of speech defects, the plant is also designed as a research center to develop new techniques for the correction of speech defects and to train qualified instructors in this field. According to Dr. Palmer, there are only about 1,000 qualified speech correctionists to-day, whereas at least twenty times this many are needed.

"Since the Institute of Logopedics was founded in 1934, such a center has been our dream," Dr. Palmer said. "It is so planned that it can provide full correction facilities for every type of speech defect, including cerebral palsy, aphasia, which is another type of brain injury, stuttering, cleft palates, and articulation. All buildings are scientifically designed and the entire plant is so flexible that facilities can be enlarged as the need arises.

"It is our hope that this center will become a hub of research for the development of new techniques of speech correction, which will be made available to other clinics throughout the country and so lead to an adequate program of assistance to the nation's 4,000,000 speech-handicapped. Thus, it will be possible to develop a national program for those who are to-day the country's largest most neglected group of the handicapped and whose numbers are increasing by approximately 90,000 annually."

The administration and training building, center of the development, is unique in design and construction for this type of institution, Dr. Palmer said, with the outside brick walls carrying the entire weight of the building. The interior walls carry no ceiling weight and can be removed as the institute grows.

Research laboratories and individual training rooms for the chil-

dren, together with a kitchen for hot lunches, will occupy the first floor of the building. Here also will be placed a complete dark room and a photographic studio. Plans contemplate an air-conditioning plant to provide year-around temperature control. On the upper floors of the building will be placed the offices, the case-history rooms, a soundproof recording studio, a small auditorium, and lecture rooms.

Living quarters for the young trainees have been planned to eliminate all atmosphere of an institution, Dr. Palmer said further. The children will live in four-plexes, consisting of four individual apartments, each providing housing for three trainees and a house mother, who will prepare meals and care for the youngsters.

Like the entire plant, the section for the training of the cerebral palsied has been scientifically designed from all aspects, Dr. Palmer stated. This section will be built around a hollow square and is so planned that none of these handicapped will have to cross a road or a street. Ramps will lead into the rear entrance of these housing units, with steps at the front for the use of the children as they are taught to walk.

The cerebral-palsy unit will include a playground to provide physical education and a model farm where the trainees can be taught truck farming, chicken raising, and other agricultural pursuits to equip them to be self-supporting when they leave the institute.

"Our great concern," said Dr. Palmer, "is to provide these people with normal communication and equip them with the 'tools' necessary to lead constructive lives. No effort will be made to create 'ideal' housing conditions for the cerebral palsied," he explained, "since the object will be to prepare them for living in a normal world."

In the fourteen years since it was founded as an outgrowth of a department of logopedics established by Dr. W. M. Jardine, President of the University of Wichita, and former Secretary of Agriculture under Coolidge, the institute has given individual training to more than 3,000 cases of speech defects. Most of these cases have been either corrected or substantially improved, according to Dr. Palmer.

Clinic Staff Sets Up Supplementary Practice

The Lancaster County (Pennsylvania) Guidance Clinic has for ten years been offering a broad community mental-hygiene service both for adults and for children. This year the county medical society suggested that the clinic should not give treatment to those who could afford such treatment elsewhere, and the board of the

mental-hygiene association, which is responsible for the clinic, acquiesced with this suggestion. The staff of the clinic, which consists of Dr. Psyche Cattell, Mrs. Evelyn R. Webb, and Dr. Robert P. Kemble, wished to continue making services available to all income groups and for this purpose has opened offices for "private practice" in a separate location at 224 North Duke Street, Lancaster. The clinic will continue at 129 East Orange Street with its regular schedule, and the staff members, as associates, will supplement this in their other offices. They would like to correspond with other clinic teams that are contemplating similar plans or that are already operating in this manner.

"Inquiring Parent" Radio Recordings Available

Series II of "The Inquiring Parent" radio recordings, which are discussions of Dr. Luther E. Woodward with a parent, are now available through The National Committee for Mental Hygiene. The topics discussed in the fourteen programs selected cover a wide range of interest and problems that are of concern to all parents and others who have the responsibility of the care and guidance of children. In each program everyday problems that arise in almost all family situations are discussed. The programs are designed to increase the listener's understanding of the motivation behind problems of child behavior and suggest constructive ways for dealing with them within the family unit or in the community.

The price is $50 for a single set with discounts of 10 per cent to 30 per cent for larger orders.

The topics of the fourteen programs in this series are: (1) *Humor in the Home;* (2) *Moral Training of Children;* (3) *Children's Allowances and the Family Money;* (4) *What About the Comics?;* (5) *Parents Through the Eyes of Teen Agers;* (6) *Junior Has His Troubles;* (7) *What Can Father Do?;* (8) *When Illness Strikes;* (9) *Sex Education in the Home* (four additional programs on sex education will be recorded if there is sufficient demand); (10) *When the New Baby Comes;* (11) *Dealing with Prejudice;* (12) *When Children Are Different;* (13) *Dealing with Destructiveness;* and (14) *Popular and Unpopular Children.*

News of Mental Hygiene Societies

Illinois

A recent news letter of the Illinois Society for Mental Hygiene reports that on June 25, 1948, the Children's Commission of the society held its first meeting to begin formulating a program to

provide state-wide public psychiatric services and facilities for children, now almost totally lacking. To quote the news letter:

> "The program will be brought to the next legislature—*backed by public support.* This support will be gained in a campaign to be conducted by the society in much the same manner as last year, when it succeeded in obtaining legislative appropriations for increased personnel and facilities in state hospitals.
>
> "The commission's members are psychiatrists, heads of social agencies, legal authorities, and other outstanding individuals concerned with children and recognized as authorities in all phases of the problem.
>
> "The commission will work through the summer to complete its recommendations by early fall. It will review reports of a number of investigating bodies which have conducted studies and surveys in past years. The needs—it is agreed—have been made abundantly clear. What is wanted now is the *actual program;* the commission has accepted the responsibility of producing it.
>
> "The campaign is being undertaken at a time when civic leaders, the press, women's clubs, and other organizations are aroused by the Heirens, Lang, and Adams cases, as well as the rise in juvenile delinquency. The public has been aroused similarly before, but now . . . more people than ever before understand that emotional disturbances are largely responsible and that they can be dealt with *if the proper services and facilities are provided.*"

A three-day institute, for the faculties of nursing schools in northern Illinois, on how mental hygiene should be interwoven with the whole nursing procedure, will be held November 4, 5, and 6 at the Illini Building, South Wood street. The Illinois Society for Mental Hygiene is conducting the institute in coöperation with the Illinois State Department of Registration and Education.

Dr. Francis J. Gerty, Medical Director of the University of Illinois Department of Psychiatry, will keynote the institute. Outstanding lecturers will lead the discussions.

This is a closed institute and attendance is limited to representatives selected by each of the nursing schools in the area.

Wisconsin

The Wisconsin Society for Mental Hygiene has issued a reply to a statement recently made by the Wisconsin Citizens Public Expenditure Survey on the ratio of patients to employees and on expenditures per capita for the maintenance of patients in Wisconsin institutions for the mentally ill. According to this statement, which was based upon a release of the United States Public Health Service on patients in state mental institutions for 1946, "the ratio of patients to full-time employees in Wisconsin institutions is lower than all other states in the Union except New Hampshire and the District of Columbia. Compared to a national average of 6.2 patients per

employee, Wisconsin had only 3.9. Expenditures per capita for maintenance of patients in Wisconsin were $644.82, compared to a national average of $432.72 and were exceeded only by the District of Columbia.'' To this, the Wisconsin Society replies in part:

> ''The recent release of 1946 statistics by the United States Public Health Service *re* patients in state mental institutions throughout the country is an excellent example of the inadequacy of figures as such. Because the state hospitals of Wisconsin share responsibility for care of the mentally ill with 35 county hospitals in addition to the two mental hospitals in Milwaukee County, the figures for this state are incomplete as reported. The result is a totally false evaluation in comparison with other states. This applies particularly to the ratio of patients to employees and to money expended for patient care.
>
> ''On the face of the figures as they appeared in the above mentioned report, the economy-minded 'researcher' on public expenditures has a point for his statement: 'These comparative figures appear to refute statements heard frequently at state budget time and during legislative sessions that Wisconsin's mental institutions are undermanned and ill-supported.' Actually, the facts support the statements of grave need for correcting present deficiencies in personnel, equipment, and buildings.
>
> ''The error lies in the inadequacy of the information supplied by the state. The United States Public Health Service blanks requesting data *re* the mentally ill are sent annually to state hospitals throughout the country. This is proper, since every state except Wisconsin and, to a certain extent, Iowa houses and treats all of its mentally ill in state mental institutions. Wisconsin, however, cares for 85 per cent of her mentally ill patients in tax-supported institutions other than the state hospitals. Statistics from the state hospitals alone, therefore, fail to account for this large proportion of the patients. Figures for the state as a whole comparable to those of other states can, therefore, only be gained by reporting all the tax-supported mental institutions in the state.
>
> ''Mendota and Winnebago State Hospitals, the two state institutions receiving the mentally ill directly from communities, house and treat the acute and recently ill patients who require intensive treatment and also the chronic mentally ill whose physical and mental needs cannot be properly cared for by the personnel and equipment available in the county hospitals, excepting Milwaukee County. (The latter county, being a large metropolitan area, has for many years provided two hospitals: the Hospital for Mental Diseases for the acutely and recently ill mental patients and the Asylum for Chronic Insane for the chronic or stationary mentally ill residents of the county.)
>
> ''The chronic or stationary patients from the other counties of the state who have become well stabilized and who require a minimum of supervision are transferred as soon as possible from the state hospitals to one of the 35 county institutions. Some are committed directly to the county institutions by the courts and never enter the state hospitals for any attention. These patients can be supervised in large units by one attendant. Many of them are also able to help to run the industrial and farm units of the county institutions. For obvious reasons their per capita cost is much less than that of patients in the state hospitals.

Whether or not the present provisions in every county are adequate to meet their relatively simple needs is a question that can properly be considered elsewhere.

"*In other states the state hospital statistics automatically include all three classes of patients. . . .*

"The actual ratio [in Wisconsin] of one employee to 6.05 mentally ill patients is only slightly below the national average of 6.2. The national ratio is *affected by figures from many very backward states.* In other words, there is no particular comfort to be gained from the fact that Wisconsin is 'average.' Furthermore, few realize until they stop to study the situation that the term 'employees' includes all the people who have to do with the routine work, repair, and maintenance of the hospitals. The professionally skilled people who have direct contact with the patients and who carry responsibility for treatment represent a very small proportion of the total number of employees.

"*The greatest shortage in employees,* the type of employees the lack of which causes such extreme anxiety to those who understand the unnecessary suffering and financial loss incurred through short-sighted economy, *falls in this professional group.* If the legislature in 1949 appropriates sufficient funds for the professional personnel (doctors, nurses, psychologists, therapists, and social workers) requested at the 1947 session, the state ratio would still be all too close to the national average, about one employee to five patients. In other words, even the correction of the critical shortage in professional personnel would still leave Wisconsin very close to the average for the nation.

"The average daily per capita *expenditure* for Wisconsin's mentally ill in comparison with other states as well as the national average is open to similar qualifications. The average annual expenditures for patients in the two state hospitals in 1946 is reported by the United States Public Health Service as $644.82 or $1.77 per day. This *appears* to be generous in contrast with the reported national average for 1946 of $436.72 or $1.20 per day. Both figures, however, are disgracefully low when compared with the modest minimum set by the American Psychiatric Association of $5.00 per diem for active treatment hospitals and $2.50 for hospitals caring for low-cost stabilized chronically ill patients presumably requiring comparatively little personal attention.

"It is impossible to figure the actual per diem, including all tax-supported mental institutions in Wisconsin, because of differences in bookkeeping within the several counties. This renders the figures not comparable even within the state. At the present time the per diem cost in Mendota and Winnebago hospitals is approximately $2.50, still running too far below the minimum standard of $5.00 set by the American Psychiatric Association for hospitals providing treatment for the acutely and recently ill. There is evident need for the passage at the next session of the legislature of a law requiring a uniform method of bookkeeping in all tax-supported institutions.

"Wisconsin has so far never been especially consistent in appropriating funds and providing staff for the tax-supported hospitals. Wisconsin General Hospital has somewhat more than 1,000 beds for the purpose of diagnosing and treating patients sick from all manner of diseases. This hospital includes a neuropsychiatric unit of approximately 80 beds. The per diem rate is reported at this time as $11.00.

"Mendota and Winnebago State Hospitals are designed to give

diagnosis and active treatment to people sick from various types of mental illness. While these hospitals are limited chiefly to mental disorders, quarters, equipment, and staff of the same high caliber as Wisconsin General Hospital are needed to insure prompt attention and the type of treatment that speeds recovery.

"For a number of reasons, the *cost of operation of the state mental hospitals* in Wisconsin has materially increased without comparable actual improvement in the service rendered. During the past few years employees have been given twelve holidays or equivalent time off. Sick leave has been interpreted more liberally so that employees now average about six days sick leave per year. The work week has been reduced. At the present time there is a forty-hour work week in most positions with 20 per cent additional compensation for overtime. Many of the county hospitals, however, are reported as still on a twelve-hour day. The state services have been reclassified and higher salary ranges established. All these factors have increased the cost of operation of the state hospitals without comparable improvement of the services to the patient.

"Statistics as such in no way indicate the type or quality of service provided for patients. Attempts to measure the adequacy of treatment in terms of low costs is not practicable in providing for the sick any more than in other aspects of life. The kind of employees as well as the kind of food and equipment are extremely important to recovery. This is especially true of the professional people who have personal contact and responsibility for the patients.

"Concern should not be to keep the cost of treatment at an impossible low figure, but to see how the tax dollar can be used to shorten the period of illness and return the patient quickly to his home and job."

Recent Appointments

Dr. Karl Menninger has resigned as manager of Veterans Administration hospital at Topeka, Kansas, to become chairman of the dean's committee and senior consultant to the hospital. The resignation was effective July 25, 1948.

Dr. Menninger has been succeeded by Dr. Frank Casey, who has served under Dr. Menninger as chief of professional services at the Topeka hospital since January 1, 1946.

Since Dr. Menninger's appointment as manager at Topeka on December 1, 1945, the hospital has been transformed into the Veterans Administration's largest training center for badly needed psychiatrists and allied personnel. By his emphasis on intensive therapy, he has achieved unprecedented results in the treatment of veterans suffering from mental disorders.

Dr. Menninger is also a trustee and a director of the education department of the world-famous Menninger Foundation at Topeka. The foundation, in addition to its private operations, provides for the training of residents in neuropsychiatry for the Veterans Admin-

istration, conducts research into psychiatric problems, supervises a school of psychiatric nursing, and furnishes consultants and attendants for the care of mentally ill veterans at the Topeka hospital.

Dr. Casey is a native of Goldsboro, North Carolina. He obtained his A.B. degree in June, 1925, from Guilford College, Guilford, North Carolina, and his M.D. degree from the George Washington University School of Medicine in Washington, D. C., in 1931. He served his interneship at St. Elizabeths Hospital in Washington. He also took residency training in psychiatry at St. Elizabeths Hospital.

Dr. Casey is a member of the Shawnee County (Kansas) Medical Society and of the Kansas Medical Society. He is a diplomate of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association, and Vice President of the Kansas Psychiatric Society.

Prior to World War II, he was assigned to Veterans Administration hospitals at Lexington, Kentucky, and Perry Point, Maryland.

During World War II he served in the Army Medical Corps, both at stations in this country and in the European theater of operations. He was released from active duty with the rank of lieutenant colonel.

After his discharge from the service, he was assigned to the Veterans Administration hospital at Gulfport, Mississippi, for about three months. He then became chief of professional services at Topeka.

He is the author of a number of publications dealing with psychiatric problems.

Announcement has been made of the appointment of Dr. Leo H. Bartemeier, associate professor of psychiatry, Wayne University College of Medicine, Detroit, Michigan, and Dr. Carlyle Jacobsen, Dean of the Graduate School, State University of Iowa, Iowa City, Iowa, to the National Advisory Mental Health Council. Dr. Bartemeier and Dr. Jacobsen succeed Dr. David Levy, assistant professor of psychiatry, Columbia University, New York, New York, and Dr. Edward A. Strecker, professor of psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, whose terms on the council expired on June 30, 1948.

Dr. David Levy has been appointed to serve on the Research Study Section, an advisory body of the council, and Dr. Grover F. Powers, professor of pediatrics, Yale University, New Haven, Connecticut, has also been appointed to the Research Study Section, replacing Dr. Charles A. Janeway, professor of pediatrics, Harvard Medical School, Boston, Massachusetts, upon the latter's resignation from the Research Study Section.

Grosvenor B. Pearson, M.D., Director of the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, wishes to announce the following appointments to the staff:

Frederick L. Weniger, M.D., has been appointed director of the mental-health clinic, the out-patient division of the institute.

Robert A. Clark, M.D., clinical director, will be away from the institute on leave of absence for a year to attend the International Congress on Mental Health in London in August, 1948, and to study under C. G. Jung at the Institute of Analytical Psychology in Zürich, Switzerland.

Announcement is also made of the appointment of Ralph N. Zabarenko, M.D., as associate research psychiatrist. His work will be closely connected with the division of neurophysiology.

The following reorganization of the division of neurophysiology in the department of research has taken place: Robert A. Patton, Ph.D., has been named research neurophysiologist and head of the animal research laboratory. Newly appointed resident fellows are Roger W. Russell, Ph.D., John F. Pierce, M.S., and Harry W. Braun, Ph.D., respectively, associate professor of psychology, instructor of electrical engineering, and lecturer in psychology at the University of Pittsburgh, and Francis J. Pilgrim, M.S. Other appointments in neurophysiology are Frank H. Palmer, M.S., John C. Townsend, M.S., and Lucy M. Braider.

A research grant of $6,120 has been received from the United States Public Health Service for a continuation of the present research program dealing with the effects of electro-shock convulsions on learning and retention in the rat. In addition, a grant of $5,600 has been received from the Williams-Waterman Fund of the Research Corporation, New York, for investigation of the effects of glutamic acid and other amino-acids on learning in the rat.

Recent Publications

The Group for Advancement of Psychiatry has prepared reports on shock therapy, the psychiatric social worker in the psychiatric hospital, medical education, commitment procedures, and public psychiatric hospitals. One copy of any report is available to any professional person on request, and additional copies may be secured from the Chairman of the Group for Advancement of Psychiatry, 3617 West 6th Street, Topeka, Kansas, at 10 cents a copy, plus postage.

The new edition of the *Public Welfare Directory* for 1948 is now available. The directory is a complete guide for welfare workers and includes listings of the personnel of federal, state, and local welfare agencies. Included also for each state is a statement on

the administration of public assistance, information on interstate correspondence procedures, and the sources of vital statistics.

A statement on the disclosure of old-age and survivors' insurance information, tabular information on residence requirements for general assistance and the categorical programs for each state, and a list of other directories available are included in the appendix.

Copies may be obtained from the American Public Welfare Association, 1313 E. 60th St., Chicago 37, Illinois, at the following prices: single copies, $1.80 each; 10 to 25 copies, $1.62 each; 25 or more, $1.44 each.

A new publication, *World Research in Alcoholism*, is announced by the Illinois Department of Public Welfare. It is primarily a bibliography for the professional staffs of the state hospitals and will be issued monthly.

Wanted: Copies of Mental Hygiene for January 1948

The National Committee for Mental Hygiene is short of copies of Mental Hygiene for January, 1948. As requests for copies of this issue are still coming in, the Committee would appreciate it if any subscriber who does not care to keep his copy would return it to this office, Room 916, 1790 Broadway, New York 19, N. Y.

The Committee wishes to take this opportunity to thank those who so kindly responded to previous requests for back copies of the magazine.

CURRENT BIBLIOGRAPHY *

Compiled by

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The National Health Library

Abraham, A. A. Juvenile delinquency in Buffalo and its prevention. Journal of Negro education, 17:124–33, Spring 1948.

Ackerman, Nathan W., M.D. and Jahoda Marie. The dynamic basis of anti-Semitic attitudes. Psychoanalytic quarterly, 17:240–60, April 1948.

Aesculapius at the desk. Psychiatric quarterly, 22:339–43, April 1948.

Aisenson, Milton R., M.D. Accidental injuries in epileptic children. Pediatrics, 2:85–88, July 1948.

Aldrich, Clarence K., M.D. and Coffin, Mabel. Clinical studies of psychoses in the navy. Journal of nervous and mental disease, 108:36–44, July 1948; 142–48, August 1948.

Alexander, Leo, M.D. Aggressive behavior—its psychiatric and physiologic aspects, especially in combat veterans. New England journal of medicine, 239:10–14, July 1, 1948.

Altus, William D. A note on group differences in intelligence and the type of test employed. Journal of consulting psychology, 12:194–95, May–June 1948.

Arieff, Alex J., M.D., McCulloch, Rook and Rotman, D. B., M.D. Unsuccessful suicidal attempts. Diseases of the nervous system, 9:174–79, June 1948.

Axline, Virginia M. Play therapy and race conflict in young children. Journal of abnormal and social psychology, 43:300–310, July 1948.

Axline, Virginia M. Some observations on play therapy. Journal of consulting psychology, 12:209–16, July–August 1948.

Babcock, Charlotte G., M.D. Food and its emotional significance. Journal of the American dietetic association, 24:390–93, May 1948.

Bacon, Selden D. Alcoholism in industry. Industrial medicine, 17:161–67, May 1948.

Bakeman, Pauline. Psychiatric understanding in an international social welfare setting. Journal of psychiatric social work, 17:146–53, Spring 1948.

Baker, Inez M. Uphold rights of parent and child. Child, U. S. Children's bureau, 13:27–30, August 1948.

Bakwin, Ruth M., M.D. and Bakwin, Harry, M.D. Accident proneness. Journal of pediatrics, 32:749–52, June 1948.

Bakwin, Ruth M., M.D. and Bakwin, Harry, M.D. Management of the child with mental deficiency. Journal of pediatrics, 32:611–18, May 1948.

Baldock, Edgar C. Some children live in institutions. Understanding the child, 17:73–77, June 1948.

Ballinger, Malcolm B. On-the-job training of pastors in their own hospital. Journal of pastoral care, 2:35–38, Spring 1948.

Barbour, R. F. Child guidance. Mental health, National association for mental health (London), 7:86–90, May 1948.

Barker, Wayne, M.D. Studies on epilepsy: the petit mal attack as a response within the central nervous system to distress in organism-environment integration. Psychosomatic medicine, 10:73–94, March–April 1948.

Bartemeier, Leo H., M.D. The practical application of basic mental hygiene principles by the Cornelian corner. Bulletin, Menninger clinic, 12:113–16, July 1948.

Baumgardt, David. Psychoanalysis and the Königsberger Mucker. Psychoanalytic review, 35:301–2, July 1948.

Bellak, Leopold, M.D. A note on some basic concepts of psychotherapy. Journal of nervous and mental disease, 108:137–41, August 1948.

Bellak, Leopold, M.D. and Holt, R. R. Somatotypes in relation to dementia praecox. American journal of psychiatry, 104:713–24, May 1948.

Bellsmith, Ethel B. and Edward, Joyce.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

The rôle of a social group worker at Central Islip state hospital. Journal of psychiatric social work, 17: 139–46, Spring 1948.

Bergler, Edmund, M.D. Lesbianism, facts and fiction. Marriage hygiene (Bombay, India), 1:197–202, May 1948.

Bergler, Edmund, M.D. The myth of a new national disease: homosexuality and the Kinsey report. Psychiatric quarterly, 22:66–88, January 1948.

Bergler, Edmund, M.D. Three "battles" during analytic treatment. Psychoanalytic review, 35:273–84, July 1948.

Bergler, Edmund, M.D. Three tributaries to the development of ambivalence. Psychoanalytic quarterly, 17:173–81, April 1948.

Bergler, Edmund, M.D. Typical unconscious reactions to serious illness of friends and acquaintances. Quarterly review of psychiatry and neurology, 3:143–48, April 1948.

Bettelheim, Bruno. Closed institutions for children. Bulletin, Menninger clinic, 12:135–42, July 1948.

Beyer, Evelyn. The preschool children and the five freedoms. Medical woman's journal, 55:45–49, June 1948.

Bierer, Joshua, M.D. and Ström-Olsen, Rolf, M.D. The recording of psychotherapeutic sessions: its value in teaching, research, and treatment. Lancet (London), 254:957–58, June 19, 1948.

Bigalow, Rena M., M.D. Mental hygiene principles as applied to child guidance clinics. Mental hygiene news, New York state department of mental hygiene, 18:12, May 1948.

Binger, Carl, M.D. New partnerships for psychiatry. American journal of orthopsychiatry, 18:543–47, July 1948.

Blackman, Nathan, M.D. Psychotherapy in a Veterans administration mental hygiene clinic. Psychiatric quarterly, 22:89–102, January 1948.

Blackman, Nathan, M.D. Sequelæ of military service and their treatment in a Veterans administration mental hygiene clinic. Journal of the Missouri state medical association, 45:579–82, August 1948.

Bloom, Sophia. Some economic and emotional problems of the tuberculosis patient and his family. Public health reports, U. S. Public health service, 63:448–55, April 2, 1948.

Boisen, Anton T. The minister as counselor. Journal of pastoral care, 2:13–22, Spring 1948.

Bonner, Clarence A., M.D. Who and what are sexual psychopaths? Focus, National probation and parole association, 27:103–5, July 1948.

Bostock, John. Individual or individuum: a survey of totalitarian and termite communities. Medical journal of Australia (Sydney), 1–35th yr.:593–97, May 8, 1948.

Bowditch, Henry L. Teaching the epileptic child. Green light, National association to control epilepsy, inc., 4:1–5, August 1948.

Bowman, Karl M., M.D. Psychiatry in China. American journal of psychiatry, 105:70–71, July 1948.

Boyd, David A., Jr., M.D. and Brown, D. W. Electric convulsive therapy in mental disorders associated with childbearing. Journal of the Missouri state medical association, 45:573–79, August 1948.

Brady, Mildred E. The strange case of Wilhelm Reich. Bulletin, Menninger clinic, 12:61–67, March 1948.

Brenman, Margaret and Knight, R. P., M.D. A note on the indications for the use of hypnosis in psychotherapy: an illustrative case report. Bulletin, Menninger clinic, 12:49–56, March 1948.

Brody, Matthew, M.D. The biological purpose of the dream. Psychiatric quarterly, 22:64–65, January 1948.

Brown, Luna B. Responsibility of the public agency for strengthening its clients. Journal of social casework, 29:255–60, July 1948.

Bruch, Hilde, M.D. The rôle of the parent in psychotherapy with children. Psychiatry, 11:169–75, May 1948.

Brussel, James A., M.D. The father and his adolescent son. Hygeia, 26: 420–21, 434–36, June 1948.

Bryngelson, Bryng. Personnel counseling and the speech clinic. Journal of speech and hearing disorders, 13: 107–13, June 1948.

Burlingame, C. C., M.D. Psychiatry comes of age. North Carolina medical journal, 9:236–38, May 1948.

Burnett, Waldo E., M.D. A critique of intravenous barbiturate usage in psychiatric practice. Psychiatric quarterly, 22:45–63, January 1948.

Burnette, Norman L. Occupation in the mental hygiene of the aged. Canadian nurse (Montreal), 44:355–58, May 1948.

Caldwell, John M., M.D. The present status of neuropsychiatry in the army. Military surgeon, 102:479–82, June 1948.

Caldwell, John M., Jr., M.D. The problem soldier and the army. American

journal of psychiatry, 105:46–51, July 1948.

Cameron, Eugenia S., M.D. Child guidance services in semi-rural and neglected areas; a public health project in Wisconsin. American journal of orthopsychiatry, 18:536–40, July 1948.

Cameron, Eugenia S., M.D. The community's responsibility in the national mental health program. Wisconsin state board of health bulletin, 8:275–77, April–June 1948; 309–11, July–August 1948.

Caplan, Gerald, M.D. and Bowlby, John, M.D. The aims and methods of child guidance. Health education journal, Central council for health education (London), 6:55–62, April 1948.

Carlson, Theo. The A B C of adoption. Hygeia, 26:332–33, 361–62, May 1948.

Carlson, Theo. Is your child afraid of the dark? Hygeia, 26:552–53, 594, August 1948.

Carter, Launor F. The identification of "racial" membership. Journal of abnormal and social psychology, 43: 279–86, July 1948.

Cassel, Robert H. Borderline diagnosis and organic impairment. Training school bulletin, 45:69–77, June 1948.

Chang, Teh-Shiu. Child guidance in China. School and society, 68:124–26, August 21, 1948.

Charen, Sol. Brief methods of psychotherapy—a review. Psychiatric quarterly, 22:287–301, April 1948.

Chase, Helen E. What people want from jobs. Mental hygiene news, New York state department of mental hygiene, 18:5, 8, 10, May 1948; 3–4, June 1948.

Chilman, C. William. New York state reviews its foster-care system. Social service review, 22:180–93, June 1948.

Chisholm, Brock, M.D. A new look at child health. The Child, 12:178–81, May 1948.

Chisholm, Brock, M.D. Organization for world health. Mental hygiene, 32:364–71, July 1948.

Cianci, Vincentz. A program for the home training of mentally retarded children. Training school bulletin, 45:63–68, June 1948.

Clark, Robert E. The relationship of schizophrenia to occupational income and occupational prestige. American sociological review, 13:325–30, June 1948.

Clark, Ruth M. Supplementary technique to use with secondary stutterers. Journal of speech and hearing disorders, 13:131–34, June 1948.

Cohen, Nathan E. and Harrison, George. A gang is a street club: work with it, not against it, if you want to see results. Better times, Welfare council of New York City, 29:3–4, 8, May 28, 1948.

Coleman, James C. and McCalley, J. E. Nail biting and mental health: a survey of the literature. Mental hygiene, 32:428–54, July 1948.

Collis, Eirene. The treatment and management of the "spastic" child. Public health (London), 61:150–51, May 1948.

Co-operation between physician and psychiatrist. British medical journal (London), p. 1201–2, June 19, 1948.

Crawfis, E. H., M.D. and Morrow, Guy. A study of an incentive pay roll in the motivation of psychotic patients. Occupational therapy and rehabilitation, 27:299–303, August 1948.

Current vocational rehabilitation programs for the epileptic. Green light, National association to control epilepsy, inc., 3:2–15, April 1948.

Danziger, Lewis, M.D. and Kindwall, J. A., M.D. Thyroid therapy in some mental disorders. Diseases of the nervous system, 9:231–41, August 1948.

Davidson, Allen E., M.D. Prefrontal leucotomy — selection of patients. Northwest medicine, 47:417–19, June 1948.

Davidson, G. M., M.D. Psychosomatic aspects of the Korsakoff syndrome. Psychiatric quarterly, 22:1–17, January 1948.

De Groot, A. D. The effects of war upon the intelligence of youth. Journal of abnormal and social psychology, 43:311–17, July 1948.

Delarue, Norman, M.D. Traumatic "unconsciousness" — a clinical misnomer: present concepts of states of impaired consciousness. Canadian medical association journal (Montreal), 58:457–65, May 1948.

Dershimer, Frederick W., M.D. Constructive forces in the job. Mental hygiene, 32:372–81, July 1948.

Deutsch, Albert L., M.D. and Zimmerman, Joseph, M.D. Group psychotherapy as adjunct treatment of epileptic patients: preliminary report. American journal of psychiatry, 104:783–85, June 1948.

Diethelm, Oskar M.D. Research project on the etiology of alcoholism. Quarterly journal of studies on alcohol, 9:72–79, June 1948.

Donahue, Hayden H., M.D. and others. Pentothal sodium: an adjunct in the understanding of the schizophrenic reaction. A preliminary report. Psy-

chiatric quarterly, 22:221–51, April 1948.

Dow, Frances. This you should do for your child. Parents' magazine, 23: 28–29, 96–97, July 1948.

Dumpson, James R. New developments in child welfare. Child welfare league of America, Bulletin, 27:1–6, May 1948.

Durea, Mervin A. and Taylor, G. J. The mentality of delinquent boys appraised by the Wechsler-Bellevue intelligence tests. American journal of mental deficiency, 52:342–44, April 1948.

Dymond, Rosalind F. A preliminary investigation of the relation of insight and empathy. Journal of consulting psychology, 12:228–33, July–August 1948.

Ehrenwald, Jan, M.D. Morning depression. American journal of psychotherapy, 2:198–214, April 1948.

Eisenbud, Jule, M.D. Analysis of a presumptively telepathic dream. Psychiatric quarterly, 22:103–35, January 1948.

Ellermann, Mogens, M.D. Social and clinical features of chronic alcoholism, based on a study of 231 male patients. Journal of nervous and mental disease, 107:556–68, June 1948.

Emery, Margaret A. For children who need foster care. Child, U. S. Children's bureau, 12:198–201, June 1948.

English, Oliver S., M.D. The effect of hostility upon the human organism. Mental hygiene survey, Virginia department of mental hygiene and hospitals, 10:9–14, February 1948.

English, Oliver S., M.D. and Foster, C. J. A challenge to mothers. Parents' magazine, 23:30, 74, 76, 78, 80, September 1948.

Epperson, Jane A. The process of licensing an institution. Child welfare league of America, Bulletin, 27: 7, 12–14, May 1948.

Escalona, Sibylle. Some considerations regarding psychotherapy with psychotic children. Bulletin, Menninger clinic, 12:126–34, July 1948.

Evans, Harrison S., M.D. and Collet, G. M. The Rorschach test in clinical psychiatry. Ohio state medical journal, 44:482–86, May 1948.

Evans, Jean. Case reports: Johnny Rocco. Journal of abnormal and social psychology, 43:357–83, July 1948.

Evans, Joan. How can the mental nurse contribute to the recovery of the depressed patient? Mental health, National association for mental health (London), 7:98–99, May 1948.

Evseeff, G. S., M.D. Group psychotherapy in the state hospital. Diseases of the nervous system, 9: 214–18, July 1948.

Farmer, Joseph A., M.D. A program of post-lobotomy re-education and rehabilitation. North Carolina medical journal, 9:287–91, June 1948.

The feeling of hostility. Canada's health and welfare (Ottawa), 3:4–5, June 1948. (Motion picture.)

Feigen, Samuel, M.D. Medico-legal problems of mental incompetency. New York medicine, 4:21–23, 41, July 5, 1948.

Felix, Robert H., M.D. Psychiatry comes of age: by an act of Congress money has been appropriated which is being spent on research, training, treatment, public education and prevention of mental ills. Science news letter, 54:90–91, August 7, 1948.

Felix, Robert H., M.D. Recruiting for mental health: need outruns supply three to one or five to one, maybe a hundred to one as with psychiatric nurses, and this tells of emergency steps to meet the lack. Survey graphic, 37:312–14, June 1948.

Fenske, Virginia. Supervision and licensing of child caring agencies. Child welfare league of America, Bulletin, 27:1–5, April 1948.

Fink, R. M. A state-wide experiment for mental health. Understanding the child, 17:87–88, June 1948.

Fisher, Raymond. Therapeutic implications in the use of the group in recreation with psychotics. Mental hygiene, 32:465–73, July 1948.

Fodor, Nandor. Fire and begetting. American journal of psychotherapy, 2:240–49, April 1948.

Fodor, Nandor. The Poltergeist—psychoanalyzed. Psychiatric quarterly, 22:195–203, April 1948.

Fong, Theodore C. C., M.D. Neuropsychiatric activities at Darnall general hospital. Military surgeon, 102: 365–73, May 1948.

Fox, J. T., M.D. The epileptic child. Public health (London), 61:149–50, May 1948.

Frank, Marjorie H. Volunteers in mental hospitals. Mental hygiene, 32:411–23, July 1948.

Frankel, Emil. Outcome of mental-hospital treatment in New Jersey: a statistical review of state mental-hospital activities. Mental hygiene, 32:459–64, July 1948.

Freeman, Dorothy. The California youth authority. Social service review, 22:211–33, June 1948.

Freeman, Walter, M.D. The hyperventilation syndrome. Diseases of the nervous system, 9:180–83, June 1948.

Freeman, Walter, M.D. and Watts, J. W., M.D. Psychosurgery. Bulletin, U. S. Army medical department, 8:434–35, June 1948.

Freestone, Norman W. The wish for defective speech. Journal of speech and hearing disorders, 13:119–30, June 1948.

Friedman, Paul, M.D. Can freedom be taught? The rôle of the social worker in the adjustment of the new immigrant. Journal of social casework, 29:247–55, July 1948.

Friedman, Sigmund L., M.D. Hospitals cannot turn away from the problem of the problem drinker. Modern hospital, 70:47–49, June 1948.

Frosch, John, M.D. and Impastato, David, M.D. The effects of shock treatment on the ego. Psychoanalytic quarterly, 17:226–39, April 1948.

Funkhouser, James B., M.D. The symptomatic use of electric convulsive therapy for acute psychoses of military personnel. Psychiatric quarterly, 22:204–12, April 1948.

Gamble, Clarence J., M.D. The sterilization of psychotic patients under state laws. American journal of psychiatry, 105:60–62, July 1948.

Gamble, Clarence J., M.D. Sterilizations of the mentally deficient in 1946. American journal of mental deficiency, 52:375–78, April 1948.

Garfield, Sol L. and Eron, L. D. Interpreting mood and activity in TAT stories. Journal of abnormal and social psychology, 43:338–45, July 1948.

Gauger, Adeline B., M.D. Mental deficiency in cases of organic brain damage. Medical woman's journal, 55:37–40, June 1948.

Gayle, Robert F., Jr., M.D. and Fishburn, G. W., M.D. Prefrontal lobotomy. Diseases of the nervous system, 9:242–47, August 1948.

Geoghegan, John J., M.B. Mental disease! is there any hope? Health, Health league of Canada (Toronto), p. 12, 28–29, 32, July–August 1948.

Gill, Merton M., M.D. Spontaneous regression on the induction of hypnosis. Bulletin, Menninger clinic, 12:41–48, March 1948.

Ginsburg, Sol W., M.D. Psychiatry and the social order. Mental hygiene, 32:392–406, July 1948.

Gitelson, Maxwell, M.D. The emotional problems of elderly people. Geriatrics, 3:135–50, May–June 1948.

Gitelson, Maxwell, M.D. Planned parenthood and mental hygiene. Mental hygiene, 32:424–27, July 1948.

Gitelson, Maxwell, M.D. Problems of psychoanalytic training. Psychoanalytic quarterly, 17:198–211, April 1948.

Glover, Edward, M.D. The question of lay psycho-analysis. British medical journal (London), p. 308–9, August 7, 1948.

Glover, Katherine. Learning to live together: New Haven experiment in neighborliness. Child, U. S. Children's bureau, 13:18–20, 31, August 1948.

Goodman, Alice W. Psychiatric technicians; New Jersey's answer to the nursing shortage. Trained nurse and hospital review, 121:106–7, August 1948.

Gordon, Alfred, M.D. Psychoneuroses in relation to general medicine. Medical record, 161:165–68, March 1948.

Greer, Ina M. Token relationships: a study in counterfeit interaction. Journal of pastoral care, 1:1–5, Winter 1947.

Gregg, Alan, M.D. Lessons to learn. Bulletin, Menninger clinic, 12:26–30, January 1948.

Griffiths, Nye W. Give them courage to try. Crippled child, 25:6–7, 25–26, April 1948.

Grigg, Austin E. Criminal behavior of mentally retarded adults. American journal of mental deficiency, 52: 370–74, April 1948.

Grotjahn, Martin, M.D. Some clinical illustrations of Freud's analysis of the uncanny. Bulletin, Menninger clinic, 12:57–60, March 1948.

Gundry, Charles H., M.D. Mental hygiene in the child health program. Canadian journal of public health (Toronto), 39:255–61, July 1948.

Gutheil, Emil A., M.D. Dream and suicide. American journal of psychotherapy, 2:283–94, April 1948.

Hahn, Pauline B. Johnny Rocco—teaching material for elementary students. Journal of abnormal and social psychology, 43:384–90, July 1948.

Halle, Louis, M.D. and Landy, Arthur. The integration of group activity and group therapy. Occupational therapy and rehabilitation, 27:286–98, August 1948.

Hamilton, Donald M., M.D. and Ward, G. M., M.D. The hospital treatment of involutional psychoses. American journal of psychiatry, 104:801–4, June 1948.

Hamilton, Portia. When you and your daughter disagree. Parents' magazine, 23:30, 71, August 1948.

Hauser, Abe, M.D. Present status of

electric shock therapy. Diseases of the nervous system, 9:254–57, August 1948.

Hawley, Paul R., M.D. The rôle of motivation in recovery from illness. American journal of psychiatry, 104: 753–57, June 1948.

Hitschmann, Edward, M.D. Boswell: the biographer's character: a psychoanalytic interpretation. Psychoanalytic quarterly, 17:212–25, April 1948.

Hobbs, Albert H. and Lambert, R. D. An evaluation of "Sexual behavior in the human male." American journal of psychiatry, 104:758–64, June 1948.

Hohman, Leslie B., M.D. We need facts in psychiatry. Child, U. S. Children's bureau, 13:25–26, August 1948.

Hollingshead, Laurance. Costs and standards of service. Child welfare league of America, Bulletin, 27:1–5, June 1948.

Horwitz, William A., M.D. and Kalinowsky, L. B., M.D. Combined insulin coma and electric convulsive therapy in schizophrenia. American journal of psychiatry, 104:682–85, May 1948.

Hubbard, Marcella W. Art for happy citizens. Understanding the child, 17:78–80, June 1948.

Hulse, Wilfred C., M.D. Group psychotherapy with soldiers and veterans. Military surgeon, 103:116–21, August 1948.

Hunter, Harriot, M.D. The treatment of epilepsy. Diseases of the nervous system, 9:203–9, July 1948.

Hunter, Harriot, M.D. and Gorton, M. L., M.D. The value of a psychiatric consultant to a university student health service. Journal-Lancet, 68: 201–5, May 1948.

Hunter, Richard C. Something can be done. General federation clubwoman, General federation of women's clubs, 28:8, 62, May 1948.

Huston, Paul E., M.D. and Strother, C. R. The effect of electric shock on mental efficiency. American journal of psychiatry, 104:707–12, May 1948.

Hyde, Robert W., M.D. and others. Effectiveness of games in a mental hospital. Occupational therapy and rehabilitation, 27:304–8, August 1948.

Hyde, Robert W. and York, R. H. A technique for investigating interpersonal relationships in a mental hospital. Journal of abnormal and social psychology, 43:287–99, July 1948.

Jacobsen, Virginia. Influential factors in the outcome of treatment of school phobia. Smith college studies in social work, 18:181–202, June 1948.

Jacobson, J. Robert, M.D. Practical methods of group psychotherapy. Psychiatric quarterly, 22:270–86, April 1948.

Jersild, Arthur T. The administrator and child development. NEA journal, National education association, 37:285–86, May 1948.

Jetter, Lucille E. Some emotional aspects of prolonged illness in children. Public health nursing, 40: 257–60, May 1948.

Johnson, Chester E., Jr., M.D. and Sherman, J. E., M.D. The clinical significance of the Rorschach test. American journal of psychiatry, 104: 730–37, May 1948.

Johnson, Hiram K., M.D. Psychoanalysis—a critique. Psychiatric quarterly, 22:321–38, April 1948.

Johnson, Ina G. Can bad teeth affect personality? Hygeia, 26:566, August 1948.

Jonas, Adolph D., M.D. Propylthiouracil in the treatment of the anxiety state. Medical record, 161:422–26, August 1948.

Kadis, Asya L. and Lazarsfeld, Sofie. The respective rôles of "earliest recollections" and "images." American journal of psychotherapy, 2:250–55, April 1948.

Kalichman, N., M.D. The treatment and theory of prolonged insulin coma—with a case presentation. Psychiatric quarterly, 22:213–20, April 1948.

Kanner, Leo, M.D. Psychiatric problems of adolescence. Round table discussion. Pediatrics, 1:668–83, May 1948.

Kant, Otto, M.D. Clinical investigation of simple schizophrenia. Psychiatric quarterly, 22:141–51, January 1948.

Karpman, Benjamin, M.D. Conscience in the psychopath: another version. American journal of orthopsychiatry, 18:455–91, July 1948.

Karpman, Benjamin, M.D. Coprophilia: a collective review. Psychoanalytic review, 35:253–72, July 1948.

Kastein, Shulamith. Speech therapy in cerebral palsy. Journal of rehabilitation, 14:17–20, 25, June 1948.

Keddie, James A. G., M.D. Child guidance in Scotland. Health bulletin, Chief medical officer of the Department of health for Scotland, 6:23–25, April 1948.

Keene, Jane. What to do about jealousy. Parents' magazine, 23:31, 59–60, 62, July 1948.

Keller, Mark. Alcoholism among col-

lege students. College health review, Division of hygiene and public health, School of medicine, Howard university (Washington, D. C.), 12: 1, 5–7, February–April 1948.

Kemp, William N., M.D. The mind can be injured, too. National safety news, 57:34–35, 82, June 1948.

Kennedy, Alexander, M.D. Juvenile delinquency with special reference to remand homes: discussion. Proceedings of the Royal society of medicine, Section of psychiatry (London), 41: 197–208, April 1948.

Kennedy, Cyril J. C., M.D. and Anchel, David, M.D. Regressive electric-shock in schizophrenics refractory to other shock therapies. Psychiatric quarterly, 22:317–20, April 1948.

Kennedy, Foster, M.D. Psychological aspects of deafness. Hearing news, American hearing society, 16:1, 14, 16, 18, June 1948.

Kent, George. Home instead of hospitals: mental patients—thousands of them each year—make notable gains in health and happiness under the family care system now used by ten states. Survey graphic, 37: 315–17, 327–28, June 1948.

Kimmelman, George. Moral maturity and psychology. (Review of "Man for himself" by Erich Fromm.) American journal of orthopsychiatry, 18: 552–54, July 1948.

Kirby, Joyce. The child placing agency and the court. Child welfare league of America, Bulletin, 27:5–7, 13–14, June 1948.

Kobler, Fritz, M.D. Description of an acute castration fear, based on superstition. Psychoanalytic review, 35:285–89, July 1948.

Kohl, Richard N., M.D. The psychiatric aspects of obstetric nursing. American journal of nursing, 48: 422–25, July 1948.

Koyl, Jean. Value of casework interviews preceding psychiatric treatment of adults. Smith college studies in social work, 18:203–22, June 1948.

Kraemer, Manfred, M.D. Dyspepsia in the army—mental disease in soldiers with gastrointestinal complaints. Military surgeon, 102:292–97, April 1948.

Kris, Else B., M.D. Bronchial asthma; a contribution to the relation of emotional factors to bronchial asthma. Psychiatric quarterly, 22:257–69, April 1948.

Krjazhev, V. J. Experimental neurosis due to emotional shock. American review of Soviet medicine, 5:132–33, July 1948.

Kubie, Lawrence S., M.D. The future of preventive psychiatry. Mental hygiene news, Connecticut society for mental hygiene, 24:1–7, April 1948.

Kubie, Lawrence S., M.D. Psychiatric implications of the Kinsey report. Psychosomatic medicine, 10:95–106, March–April 1948.

Kupper, William H., M.D. and Rubin, B. G. A case study of a proselyte from Catholicism to Judaism. Journal of nervous and mental disease, 107:575–78, June 1948.

Lane, Helen S. Some psychological problems involved in working with the deaf and the hard of hearing. Journal of rehabilitation, 14:24–29, 36, April 1948.

Laycock, Samuel R. Is alcohol education a mental hygiene problem? Understanding the child, 17:89–91, June 1948.

Lehrman, Philip R., M.D. A. A. Brill in American psychiatry. Psychoanalytic quarterly, 17:155–60, April 1948.

Lehrman, Samuel R., M.D. Preventive military psychiatry in the light of impending military conscription. Psychiatric quarterly, 22:302–16, April 1948.

Leitch, Mary, M.D. A commentary on the oral phase of psychosexual development. Bulletin, Menninger clinic, 12:117–25, July 1948.

Leland, Bernice. Distinguishing the remedial child from the child in need of special education. Journal of exceptional children, 14:225–30, 253, May 1948.

Lemkau, Paul V., M.D. What can the public health nurse do in mental hygiene? Public health nursing, 40: 299–303, June 1948.

Lenroot, Katharine F. Children in a free society. The child, U. S. Children's bureau, 13:2–5, July 1948.

Leshan, Lawrence. A case of schizophrenia, paranoid type. ETC.: a review of general semantics, 5:169–73, Spring 1948.

Levin, A. J. Maine, McLennan, and Freud. Psychiatry, 11:177–91, May 1948.

Levin, Max, M.D. Bromide psychoses: four varieties. American journal of psychiatry, 104:798–800, June 1948.

Levine, Maurice, M.D. An orientation chart in the teaching of psychosomatic medicine. Psychosomatic medicine, 10:111–13, March–April 1948.

Levy, David M., M.D. Anti-Nazis: criteria of differentiation. Psychiatry, 11:125–67, May 1948.

Liber, Benzion, M.D. Where is the individual? Medical record, 161: 173–74, March 1948.

Licht, Sidney, M.D. The prescription of occupational therapy. New York state journal of medicine, 48:1032–34, May 1, 1948.

Lightowler, Edward. ". . . And nobody cares for me!" Mental health, National association for mental health (London), 7:94–96, May 1948.

Lindsay, Donald S., M.D. Psychotherapy in schizophrenia. Canadian medical association journal (Montreal), 59:142–44, August 1948.

Line, William. Human relations and industrial health. Canadian medical association journal (Montreal), 58: 484–86, May 1948.

Lipkin, Stanley. The client evaluates nondirective psychotherapy. Journal of consulting psychology, 12:137–46, May–June 1948.

Lipton, Harry R., M.D. An analysis of thirty-one individuals examined while awaiting trial in federal court. Journal of criminal law and criminology, 38:595–612, March–April 1948.

Lipton, Harry R., M.D. Compulsive neurotic criminalism with hysterical features based upon sexual psychopathy: a case study. Journal of nervous and mental disease, 108: 149–56, August 1948.

Lipton, Samuel D., M.D. and Kezur, Edward, M.D. Dissociated personality: status of a case after five years. Psychiatric quarterly, 22: 252–56, April 1948.

Lolli, Giorgio. Treatment of alcohol addiction. Postgraduate medicine, 4:26–28, July 1948.

Lowry, Fern. Case-work principles for guiding the worker in contacts of short duration. Social service review, 22:234–39, June 1948.

Luborsky, Lester B. Psychometric changes during electric shock treatment. Journal of nervous and mental disease, 107:531–36, June 1948.

Luchins, Abraham S. Forming impressions of personality: A critique. Journal of abnormal and social psychology, 43:318–25, July 1948.

McDaniel, Thomas W., Jr., M.D. and Diamond, M. A., M.D. A study of 700 discharged neuro-psychiatric casualties and follow-up. Diseases of the nervous system, 9:148–53, May 1948.

MacKinnon, Archibald L., M.B. Electric shock therapy in a private psychiatric hospital. Canadian medical association journal (Montreal), 58: 478–83, May 1948.

McKnight, William K., M.D. Care of patient's family in a private mental hospital. Mental health bulletin, Pennsylvania department of welfare, 25:6–8, January 15, 1948.

Maeder, LeRoy M. A., M.D. Social psychiatry. Pennsylvania medical journal, 51:880–84, May 1948.

Malmo, Robert B. Psychology in modern industry. Canadian medical association journal (Montreal), 58: 452–54, May 1948.

Manley, Florence. Mental hygiene—a new type of in-service education. Health news, New York state department of health, 25:73, 75, April 26, 1948.

Marcus, Grace F. Family casework in 1948. Journal of social casework, 29:261–79, July 1948.

Marvin, Dorothy. Don't force your child to be a yes man. Parents' magazine, 23:43, 105–6, September 1948.

Masserman, Jules H., M.D. Mental hygiene in a world crisis. Diseases of the nervous system, 9:210–13, July 1948.

Maudsley, Henry F., M.D. Some ideals for a psychiatric service. Medical journal of Australia (Sydney), 1–35th yr.:581–86, May 8, 1948.

Mayer, Edward E., M.D. Prefrontal lobotomy and the courts. Journal of criminal law and criminology, 38: 576–83, March–April 1948.

Meadows, Paul. Toward a socialized population policy. Psychiatry, 11: 193–202, May 1948.

Mellon, Evelyn E. How to raise a better baby. Parents' magazine, 23: 35, 94, 96, 98, 100, September 1948.

Menninger, Karl A., M.D. The veteran—and don't forget: one of the leaders in "rehabilitation" states his personal philosophy, which sets a warm heart and the most modern science to keeping our consciences alive. Survey graphic, 37:333–37, July 1948.

Menninger, William C., M.D. Common physical manifestations of tension causing difficult diagnostic problems for the general practitioner. Rocky Mountain medical journal, 45:655–65, August 1948.

Menninger, William C., M.D. Facts and statistics of significance for psychiatry. Bulletin, Menninger clinic, 12:1–25, January 1948.

Merritt, Hiram H., M.D. Therapy in epilepsy. Wisconsin medical journal, 47:463–69, May 1948.

Meyer, Hans, M.D. Lack of correlation between possible Rh incompatibility and Mongolian idiocy. Journal of pediatrics, 32:564–65, May 1948.

Michaels, Joseph J., M.D. and Gay, Eleanor. Psychiatric case work and its relationship to psychotherapy. Journal of psychiatric social work, 17:123–29, Spring 1948.

Miller, Maurine R. and Ketron, F. D. He had a psychological. Journal of rehabilitation, 14:3–5, 25, June 1948.

Mittelmann, Bela, M.D. The concurrent analysis of married couples. Psychoanalytic quarterly, 17:182–97, April 1948.

Moloney, James C., M.D. The effort syndrome and low back pain. Journal of nervous and mental disease, 108:10–24, July 1948.

Morris, J. V., M.D. Delinquent defectives—a group study. American journal of mental deficiency, 52:345–69, April 1948.

Muhl, Anita M., M.D. Personalities and understanding. Medical woman's journal, 55:24–25, June 1948.

National conference on family life. [Highlights of the conference held in Washington, D. C., May 5–8, 1948.] Marriage and family living, 10:49–66, 78–79, Summer 1948.

Neustatter, Walter L., M.D. Child guidance. Public health (London), 61:191–93, July 1948.

Nielsen, Johannes M., M.D. and Thompson, G. N., M.D. Schizophrenic syndromes as frustration reactions. American journal of psychiatry, 104: 771–77, June 1948.

Norman, Sherwood. Children's prisons. Survey midmonthly, 84:182–84, June 1948.

Oberndorf, Clarence P., M.D. A. A. Brill. Psychoanalytic quarterly, 17: 149–54, April 1948.

O'Brien, John D., M.D. Psychiatric units in general hospitals. Ohio state medical journal, 44:826–27, August 1948.

Oltman, Jane E., M.D., Brody, B. S., M.D. and Friedman, Samuel, M.D. Prefrontal lobotomy: a preliminary report. Connecticut state medical journal, 12:302–4, April 1948.

O'Neil, Reba. How we conquered a fear. Parents' magazine, 23:36, 132–35, September 1948.

Outler, Albert C. A Christian context for counseling. Journal of pastoral care, 2:1–12, Spring 1948.

Overholser, Winfred, M.D. Presidential address. American journal of psychiatry, 105:1–9, July 1948.

Overstreet, Bonaro W. Better lives for all our children. National parent-teacher, 42:8–10, May 1948; 8–10, June 1948.

Ovesen, Lena V. Information, please: people in trouble need the best—and the promptest—guidance that we can give. Better times, Welfare council of New York City, 29:7–8, May 28, 1948.

Parker, Rosa B. "Elves" and walls: a program of parent education. Understanding the child, 17:81–86, June 1948.

Parry, Douglas F. Childhood school influences, as recorded by college students. Understanding the child, 17:67–72, June 1948.

Parsons, Ernest H., M.D. and Scheibel, A. B., M.D. Electroshock therapy in depressions. Journal of the Missouri state medical association, 45:583–85, August 1948.

Paster, Samuel, M.D. Psychotic reactions among soldiers of World war II. Journal of nervous and mental disease, 108:54–66, July 1948.

Pearce, John D. W., M.D. Juvenile delinquency. Mental health, National association for mental health (London), 7:90–94, May 1948.

Physical therapy in the psychiatric field. Physical therapy review, 28: 65–66, March–April 1948.

Piers, Maria W. and Neisser, E. G. Surplus energy—must it mean trouble? Hygeia, 26:406–7, 443–44, June 1948.

Pillersdorf, Louis, M.D. Psychiatric units in general hospitals. Ohio state medical journal, 44: 716–17, July 1948.

Pitrelli, Ferdinand R., M.D. Psychosomatic and Rorschach aspects of stuttering. Psychiatric quarterly, 22: 175–94, April 1948.

Poehler, Hedwig R. A habit clinic is launched. Public health nursing, 40: 263–66, May 1948.

Pollak, Maxim, M.D., Neuer, Hans, M.D. and Goldschmidt, Heinz, M.D. Tuberculosis in the mentally ill and defective. Illinois medical journal, 93:260–69, May 1948.

Potter, Howard W. Choosing and using a psychiatrist. Better times, Welfare council of New York City, 29:1–2, May 28, 1948.

Powell, John W. The dynamics of group formation. Psychiatry, 11: 117–24, May 1948.

Pratt, Jean P., M.D. Psychosomatic gynecology. Postgraduate medicine, 3:423–26, June 1948.

Preston, George H., M.D. Integrating factors in psychiatric procedure. Mental hygiene, 32:407–10, July 1948.

The psychologist in the clinic setting. Round table, 1947. S. J. Beck, Chairman. American journal of orthopsychiatry, 18:492–522, July 1948.

Rademacher, Everett S., M.D. The battle of bedtime. Parents' magazine, 23:32–33, 70, 72, July 1948.

Rademacher, Everett S., M.D. The battle of mealtime and what to do

about it. Parents' magazine, 23: 32–33, 130–31, August 1948.

Rademacher, Everett S., M.D. The homework handicap. Parents' magazine, 23:32–33, 125–29, September 1948.

Raimy, Victor C. Self reference in counseling interviews. Journal of consulting psychology, 12:153–63, May–June 1948.

Rees, John R., M.D. Mental health and world affairs. Health horizon, National association for the prevention of tuberculosis (London), p. 47–51, July 1948.

Richman, Leon H. New needs and new approaches in foster care. The child, U. S. Children's bureau, 13: 8–12, 14, July 1948.

Ripley, Herbert S., M.D. and Wolf, Stewart, M.D. Psychoses occurring among psychopathic personalities in association with inelastic situations overseas. American journal of psychiatry, 105:52–59, July 1948.

Ritchie, Oscar W. A sociohistorical survey of Alcoholics anonymous. Quarterly journal of studies on alcohol, 9:119–56, June 1948.

Roberts, David E. Theological and psychiatric interpretations of human nature. Journal of pastoral care, 1:11–18, Winter 1947.

Rochester fights cerebral palsy. Health news, New York state department of health, 25:3–6, 11, May 1948.

Roen, Philip R., M.D. Is your child a bedwetter? Hygeia, 26:344, 368, May 1948.

Rogers, Carl R., and others. The rôle of self-understanding in the prediction of behavior. Journal of consulting psychology, 12:174–86, May–June 1948.

Róheim, Géza. The song of the sirens. Psychiatric quarterly, 22:18–44, January 1948.

Rokeach, Milton. Generalized mental rigidity as a factor in ethnocentrism. Journal of abnormal and social psychology, 43:259–78, July 1948.

Rosen, Samuel R., M.D. and others. Personality types in soldiers with chronic nonulcer dyspepsia. Psychosomatic medicine, 10:156–64, May–June 1948.

Rosenfeld, George B., M.D. and Bradley, Charles, M.D. Childhood behavior sequelæ of asphyxia in infancy; with special reference to pertussis and asphyxia neonatorum. Pediatrics, 2:74–84, July 1948.

Rosenheim, Frederick, M.D. Animal identifications in a tiqueur. American journal of orthopsychiatry, 18: 529–35, July 1948.

Rotter, Julian B. and Wickens, D. D. The consistency and generality of ratings of "social aggressiveness" made from observations of rôle playing situations. Journal of consulting psychology, 12:234–39, July–August 1948.

Royal society of medicine. Section of psychiatry. Juvenile delinquency with special reference to remand homes: discussion. Proceedings of the Royal society of medicine (London), 41:197–208, April 1948.

Rubin-Rabson, Grace. Psychology in pediatrics. Journal of pediatrics, 33:128–35, July 1948.

Rubinstein, Hyman S., M.D. Use of hypnosis in neuro-psychiatric practice. Diseases of the nervous system, 9:167–73, June 1948.

Ruesch, Jurgen, M.D. The infantile personality: the core problem of psychosomatic medicine. Psychosomatic medicine, 10:134–44, May–June 1948.

Ruggles, Arthur H., M.D. Psychiatry in the modern medical school. North Carolina medical journal, 9:233–36, May 1948.

Russell, Francis W. Combating mental illness. State government, 21:146–48, 153, July 1948.

Sagarra, J. Solé, M.D. Occupational therapy in Spain. Occupational therapy and rehabilitation, 27:251–63, August 1948.

Sargant, William, M.B. Eight years psychiatric work in England. Journal of nervous and mental disease, 107:501–16, June 1948.

Saslow, George, M.D. An experiment with comprehensive medicine. Psychosomatic medicine, 10:165–75, May–June 1948.

Schmideberg, Melitta, M.D. A note on claustrophobia. Psychoanalytic review, 35:309–11, July 1948.

Schmideberg, Melitta, M.D. A note on obsessional indecision. Psychoanalytic review, 35:312–13, July 1948.

Schmideberg, Melitta, M.D. On fantasies of being beaten. Psychoanalytic review, 35:303–8, July 1948.

Schmideberg, Melitta, M.D. On reality and phantasy. Psychoanalytic review, 35:314, July 1948.

Schneider, Daniel E., M.D. Time-space and the growth of the sense of reality: a contribution to the psychophysiology of the dream. Psychoanalytic review, 35:229–52, July 1948.

Schumacher, Fred A. What service does the institution give? What may we expect of it? Child welfare

league of America, Bulletin, 27:5–7, 10–12, April 1948.

Schweiger, Elizabeth L. Do you put a price on love? Parents' magazine, 23:34, 72–73, June 1948.

Schweisheimer, Waldemar, M.D. Shock therapy in mental diseases. Trained nurse and hospital review, 121:36–39, July 1948.

Scullin, Virginia. Occupational therapy as a therapeutic measure. Mental hygiene news, New York state department of mental hygiene, 18: 3, 10, May 1948; 7, 9, June 1948.

Seashore, Robert H. and Jenssen, Ward. Personality classification and counseling techniques. Scientific monthly, 66:472–74, June 1948.

Sebire, Irene, M.B. The psychiatrist and society. Medical journal of Australia (Sydney), v. 1–35th year: 791–93, June 26, 1948.

Seeley, Evelyn. Adoptions: Maryland's better way. The outstanding effort of one state to bring order into a chaotic field, while safeguarding the interests of both children and parents. Survey graphic, 37: 255–58, May 1948.

Seidenberg, Robert, M.D. Psychiatric aspects of the everyday practice of medicine. New York state journal of medicine, 48:1256–60, June 1, 1948.

Seliger, Robert V., M.D. Alcoholism in the older age groups. Geriatrics, 3:166–70, May–June 1948.

Senn, Milton J. E., M.D. Constructive forces in the home. Mental hygiene, 32:382–91, July 1948.

Senn, Milton J. E., M.D. The psychotherapeutic rôle of the pediatrician. Pediatrics, 2:147–52, August 1948.

Sharp, Lewis I., M.D. The treatment of alcoholism. Hygeia, 26:396–97, 441–42, June 1948.

Shaskan, Donald A., M.D. and Lindt, Hendrik. The theme of the aggressive mother during group therapy: analysis of a group interview. Psychoanalytic review, 35:295–300, July 1948.

Sheplow, Samuel. Anxiety neurosis (poem). American journal of orthopsychiatry, 18:548–51, July 1948.

Sherman, Clinton C. and Charbonneau, L. O. Electric shock therapy. American journal of nursing, 48:294–96, May 1948.

Sherriffs, Alex C. The "intuition questionnaire": A new projective test. Journal of abnormal and social psychology, 43:326–37, July 1948.

Siemens, Herman, M.D., Kibblewhite, E. J. and MacDougall, J. A. A public health unit plans a mental health service. Canadian journal of public health (Toronto), 39:211–12, May 1948.

Simon, John L., M.D. Electric shock treatment in advanced pregnancy. Journal of nervous and mental disease, 107:579–80, June 1948.

Simonart, Pierre C., M.D. The Catholic hospital and our neglected mentally ill. Hospital progress, 29: 269–71, August 1948.

Skinner, John. Defining treatment aims in initial interviews. Journal of psychiatric social work, 17:133–39, Spring 1948.

Sloman, Sophie S., M.D. Emotional problems in "planned for" children. American journal of orthopsychiatry, 18:523–28, July 1948.

Sloman, Sophie S., M.D. Problems of giving child guidance in neglected areas. American journal of orthopsychiatry, 18:541–42, July 1948.

Small, Leonard. Careers in sight: the story of an experiment in vocational counseling for boys in Bellevue's psychiatric ward. Better times, Welfare council of New York City, 29:5–6, 8, May 28, 1948.

Smith, Lauren H., M.D. The development of a mental health center in a private non-profit hospital. Mental health bulletin, Pennsylvania department of welfare, 25:3–4, January 15, 1948.

Spoerl, Dorothy T. "It isn't my real name." National parent-teacher, 42: 26–28, May 1948.

Stallybrass, Clare O., M.D. Mental health in relation to the family, with some reference to the National health service act, 1946. Public health (London), 61:123–28, April 1948.

Stevenson, George S., M.D. Mental health—a look ahead. Mental hygiene, 32:353–63, July 1948.

Stevenson, George S., M.D. Our stake in the International congress on mental health. Survey graphic, 37: 349–51, 358, July 1948.

Stevenson, Stuart S., M.D. Paranatal factors affecting adjustment in childhood. Pediatrics, 2:154–61, August 1948.

Stewart, Donald, M.D. Psychiatry as applied to occupational health. Lancet (London), 254:737–40, May 15, 1948.

Stewart, Donald C. Juvenile delinquency and religion. Focus, National probation and parole association, 27: 111–13, July 1948.

Stewart, Genevieve M., M.D. When a community wants a child-guidance center. Mental hygiene, 32:455–58, July 1948.

Stoller, Alan. Social health and psychiatric service. Medical journal of

Australia (Sydney), 2–35th yr.:1–8, July 3, 1948.

Sullivan, Daniel J., M.D. Insulin subshock (subcoma) treatment of psychoses and psychoneuroses. Archives of neurology and psychiatry, 59: 184–214, February 1948.

Sullivan, Harry S., M.D. Towards a psychiatry of peoples. Psychiatry, 11:105–16, May 1948.

Therapeutic conference: the treatment of epilepsy, held in the Hurd memorial hall on October 25, 1947. Bulletin, Johns Hopkins hospital, 82: 601–14, June 1948.

Thomas, David H. H. Mental subnormality in the community. Public health (London), 61:129–32, April 1948.

Thomas, Mona. The epileptic in industry. Nursing times (London), 44:312–13, May 1, 1948.

Thornton, Nathaniel. Some mechanisms of paranoia. Psychoanalytic review, 35:290–94, July 1948.

Tow, Lillian. The case of "Johnny." Understanding the child, 17:92–94, 96, June 1948.

Trends in orthopsychiatric therapy. American journal of orthopsychiatry, 18:381–454, July 1948.

Contents: General developments and trends, by L. G. Lowrey.—Rorschach F plus and the ego in treatment, by S. J. Beck.—Play technique, by J. C. Solomon.—Treatment of the young child, by M. W. Gerard.—Character synthesis: The psychotherapeutic problem of adolescence, by Maxwell Gitelson.—Physical factors, by L. A. Lurie.—Treatment of parent-child relationships, by Rose Green.—Evolution and trends in group psychotherapy, by D. A. Shaskan.

Uhler, Claude, M.D. Are psychiatrists irreligious? Trained nurse and hospital review, 121:13–18, July 1948.

Ulett, George, M.D. and Parsons, E. H., M.D. Psychiatric aspects of carcinoma of the pancreas. Journal of the Missouri state medical association, 45:490–93, July 1948.

Van Houten, Janny. Mother-child relationships in twelve cases of school phobia. Smith college studies in social work, 18:161–80, June 1948.

Verry, Ethel. Replacements in foster family care. Child welfare league of America, Bulletin, 27:13–16, April 1948.

Von Lerchenthal, Erich M., M.D. Death from psychic causes. Bulletin, Menninger clinic, 12:31–36, January 1948.

Waal, Nic, M.D. A case of anxiety neurosis in a small child. Bulletin, Menninger clinic, 12:143–51, July 1948.

Waelsch, Heinrich, M.D. A biochemical consideration of mental deficiency: the rôle of glutamic acid. American journal of mental deficiency, 52:305–13, April 1948.

Wake, Orville W. The education of slow-learning children. Training school bulletin, 45:41–51, May 1948.

Walker, A. E., M.D. and Quadfasel, F. A., M.D. Follow-up report on a series of posttraumatic epileptics. American journal of psychiatry, 104: 781–82, June 1948.

Wallace, Mildred and Feinauer, Violet. Understanding a sick child's behavior. American journal of nursing, 48:517–22, August 1948.

Wallen, Richard. The nature of color shock. Journal of abnormal and social psychology, 43:346–56, July 1948.

Wallerstein, Helen. Setting the fee in a day nursery: a discussion of the use of the fee as an introduction to casework services in a day nursery. Child welfare league of America, Bulletin, 27:9–13, June 1948.

Wannemacher, Ethel S. The care of the patient's family in the outpatient department of a private mental hospital continued. Mental health bulletin, Pennsylvania department of welfare, 25:9–13, January 15, 1948.

Waterman, John H., M.D. Psychogenic factors in parental acceptance of feebleminded children. Diseases of the nervous system, 9:184–87, June 1948.

Watters, T. A., M.D. The ego and the eye. North Carolina medical journal, 9:323–28, July 1948.

Watts, C. A. H., M.B. Treatment of anxiety states in general practice. British medical journal (London), p. 214–16, July 24, 1948.

Weickhardt, George D., M.D. Penicillin therapy in general paresis. American journal of psychiatry, 105: 63–67, July 1948.

Weiner, Bluma B. The use of systematic classroom observation to aid in curriculum planning and guidance for young mentally retarded boys. American journal of mental deficiency, 52:331–36, April 1948.

Weiss, Edward, M.D. Psychotherapy in everyday practice. Journal of the American medical association, 137:442–48, May 29, 1948.

Welsch, Exie E., M.D. Mental health. College health review, Division of hygiene and public health, School of medicine, Howard university (Wash-

ington, D. C.), 12:1–5, February–April 1948.

White, James C., M.D. and others. Focal epilepsy: a statistical study of its causes and the results of surgical treatment. New England journal of medicine, 239:1–10, July 1, 1948.

Whitman, Roderick L., M.D. Prefrontal leucotomy: aftercare and rehabilitation. Northwest medicine, 47: 419–20, June 1948.

Wiesbauer, Henry H. Pastoral counseling. Journal of pastoral care, 2:23–28, Spring 1948.

Williams, Greer. Mountain mental hygiene. Hygeia, 26:560–61, 582, 584, August 1948.

Wilson, David C., M.D. and Suter, C. G., M.D. The attitude of the states toward collecting fees. American journal of psychiatry, 104:738–43, May 1948.

Winn, Roy C., M.B. Psychoanalysis and other forms of psychotherapy. Medical journal of Australia (Sydney), 1–35th yr.:588–93, May 8, 1948.

Winnicott, D. W. Disorders of childhood. Journal of the Royal institute of public health and hygiene (London), 11:244–45, July 1948.

Wittman, Milton. Some objectives in training for psychiatric social work. Journal of psychiatric social work, 17:129–33, Spring 1948.

Witty, Paul. The gifted child: facts and fallacies. National parent-teacher, 42:4–7, June 1948.

Woods, Walter A. The rôle of language handicap in the development of artistic interest. Journal of consulting psychology, 12:240–45, July–August 1948.

Woolhandler, Harry W., M.D. The neurodermatoses; their concept and management. Pennsylvania medical journal, 51:1108–13, July 1948.

Zimmerman, Kent A., M.D. Beginnings of a mental health program in a state and local department of health. American journal of public health, 38:811–16, June 1948.

Zimmerman, Kent A., M.D. What is mental hygiene? California's health, State department of public health, 5:365–66, May 31, 1948.

Zudick, Leonard. White school reclaims epileptics. Crippled child, 25: 10–11, 27, April 1948.

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